APPENDIX A
BLOOD AND BLOOD PRODUCT SERVICES
Community Hospital South

I. AGREEMENT

A. Except as otherwise provided in this Agreement, the Blood Center shall provide to the Client one or more of the blood and blood product services as described on Exhibit A-1 and the Client shall pay the Blood Center the service fees set forth in Exhibit A-1.

B. Transportation:

1. Unless otherwise agreed, the Blood Center shall provide to the Client routine delivery service for blood and blood product services.
2. The Blood Center shall provide to the Client emergency delivery service for the emergency delivery service fee set forth in Appendix X.
3. The Blood Center shall provide and retain ownership of transportation containers and equipment for use in providing the routine delivery service for blood and blood product services.

II. RECALLS/MARKET WITHDRAWALS

A. In the event that blood products are recalled or withdrawn due to unsuitability, the parties shall comply with the responsibilities regarding notification and other actions to be taken set forth in the Consignee/Recipient Notification of Recalls/Market Withdrawals, attached hereto as Exhibit A-2, and incorporated herein.

Indiana Blood Center
EXHIBIT A-1
BLOOD PRODUCTS/SERVICES
Community Hospital South

DESCRIPTION	SUGGESTED P-CODES	ITEM CODE	PRICE ($)
LRBC/RBC	P9016	1100, 1105, 2205	275.00
LRBC/RBC - Autologous (Administrative fee is additional)		1100, 1105, 2205	275.00
LRBC/RBC - Irradiated	P9040	1103, 1108	350.00
LRBC/RBC - Deglycerolized	P9054	1400, 1405, 2405	350.00
LRBC/RBC - Frozen	P9057	1300, 1310, 2310	350.00
LRBC/RBC - Washed	P9054	1200, 1201, 2210	350.00
Whole Blood	P9010	1000	400.00
Cryoprecipitate	P9012	3000	75.00
Cryoprecipitate - Pooled	P9012 X 5	3010	450.00
Apheresis Platelets, Leuko Reduced, Bacterial Detected	P9035	2100	650.00
Apheresis Platelets-Irradiated, Leuko reduced, Bacterial Detected	P9037	2103	705.00
- HLA Typed Surcharge		9105	150.00
AFFP (400 ml)	P9017 X 2	2001	131.00
AFFP Pediatric pack (per individual pack)		2003	32.00
Frozen Plasma < 24 hours (250 ml)	P9017	2000, 3050, 3070	54.00
Frozen Plasma - Cryo Poor	P9044	3055	70.00
CMV Neg charge	86644	5061	18.00
Irradiation fee for one to five platelet concentrates	B9006	9106	55.00
Neonatal Pack Surcharge			
- Neo 3		9120	30.00
- Neo 4		9121	35.00
- Neo 6		N/A	40.00
- Neo 8		9123	50.00
Imported Product Surcharge Fees:			
- Import fee (one fee per imported unit, per patient)		9159, 9160, 9170	150.00
- Excess fees above the Blood Center charges will be passed onto the hospital			*

Legend: LRBC – Leukoreduced Red Blood Cell
RBC – Red Blood Cell
AFFP – Apheresis Fresh Frozen Plasma
FFP – Fresh Frozen Plasma

DESCRIPTION	SUGGESTED P-CODES	ITEM CODE	PRICE ($)
Source Leukocyte	85009	3106	40.00
Segments for Crossmatching (each group of 20)		9442	20.00
Packing Whole Blood (up to 4 units)		9168	30.00
Washing Platelet (per unit) (additional fee for one FFB used in processing)	B9064	9165	75.00
One Liter Wash (per unit)	B9064	N/A	75.00
Glycerolizing & Freezing	B4001	9158	75.00
Deglycerolizing	B4001	9163	85.00
Apheresis Special Draws		N/A	*
Donor / Patient Services			
Autologous Donation Fee (per unit)	86890	9102	300.00
Autologous Apheresis Donation Fee (per donation)	86890	9102	300.00
Directed Donation Fee (per unit)		9103	300.00
Additional Handling Fees - after hours, without appointment (per unit)		N/A	200.00
Annual Storage Fee for Autologous Frozen Cells		N/A	150.00
Off-site Draw Fee (per unit)		N/A	*
After Hours Charge - Apheresis		9150	350.00
Blood Derivatives			
Rho Gam (per package)	J27790		**
V-Zig Immune Globulin *(comes in volume 125 & 625)*			**
Factor 8	J7190, J7191, J7192		**
Non-Blood Products			
Platelet Leukocyte Removal Filters			
- PLX8C	PLX8C		***
- PLX12C	PLX12C		***
Red Cell Leukocyte Removal Filters			
- RCXL1C	RCXL1C		***

Regular hours are Monday – Friday, 5:30a.m.–6:30p.m; Saturday, 6:30a.m –12:00noon (excluding holidays)
Services outside of these hours may incur additional charges

* Price based on order
** Fees are subject to change
*** Price based on the manufacturer's charge

DESCRIPTION	SUGGESTED CPT-CODES	ITEM CODE	PRICE ($)
Complete Donor Profile and NAT HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (ABS) Antibody Screen, (STS) Syphilis, ABORH, HIV 1/ HCV NAT *	87340, 86704, 86703, 86687, 86688, 86803, 86592, 86900, 86901, 86850	5502	89.00
Complete Donor Profile HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (ABS) Antibody Screen, (STS) Syphilis, ABORH	87340, 86704, 86703, 86687, 86688, 86803, 86592, 86900, 86901, 86850	5503	68.50
BMR Panel HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (STS) Syphilis, CMV, ABORH	87340, 86704, 86703, 86687, 86688, 86803, 86592	5151	67.50
Infectious Disease Profile Only HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (STS) Syphilis, HIV 1/HCV NAT *	87340, 86704, 86703, 86687, 86688, 86803, 86592	5120	74.25
Tissue Bank Profile HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (STS) Syphilis, CMV	87340, 86704, 86703, 86687, 86688, 86803, 86592, 86644	5091	64.00
Fertility Donor Profile HBSAG, HCV, HIV 1/2, HBC, (STS) Syphilis	87340, 86704, 86703, 86803, 86592	5552	58.25
ABO Group & Rh Type (donor)	86900, 86901	5030	10.50
ABO Group & Rh Type (cord)	86900, 86901	5031	12.50
Antibody Screen	86850	5200	10.50
Antibody to CMV	N/A	5060	5.50
Antibody to HB Core (EIA)	86704	5040	17.00
Antibody to HCV (EIA)	86803	5105	18.00
Antibody to HIV 1/2 (EIA)	86703	5110	17.00
Antibody to HTLV-I/II (EIA)	86687, 86688	5082	17.00
Cholesterol	82465	5220	5.50
HCV/HIV1 NAT (pool)	donor only	5007	19.25
HCV/HIV1 NAT (individual)	donor only	5011	31.00
WNV NAT (pool)	donor only	5008	11.00
WNV NAT (individual)	donor only	5012	19.25
Hepatitis B Surface Antigen (EIA)	87340	5010	17.00
Syphilis (STS)	86592	5086	5.25
Antibody to HBs (EIA)	86706	5020	15.75

DESCRIPTION	SUGGESTED CPT-CODES	ITEM CODE	PRICE ($)
Syphilis Confirmatory	86781	5090	48.75
RPR Titer		5088	11.00
RPR Titer w/FTA if ind		5089	44.00
HBsAg Confirmatory Neutralization	86382	5005	157.50
HCV Immunoblot Assay	86804	5095	152.25
HIV1 Western Blot and HIV2 Antibody Confirmation	86689	5125/5127	126.00
HIV2 Western Blot	86689	5124	156.50
HTLV Antibody by WB	86689	5096	111.50
HTLV I/II Antibody w/WB if ind	86687	5129	21.25
HIV-1 Whole Viral Lysate	Donor only	5126	124.50
CMV IgG/IgM	86644/86645	5161	54.50
GC/Chlamydia	87490, 87491, 87590, 87591	5128	64.50
Chagas	87449	5021	20.00
Chagas RIPA	86753	5121	500.00
Leishmania IFA	86717	5101	131.25
Complete Blood Count			7.50

The laboratory can be reached at Monday-Saturday. If no answer, call to have the staff paged.

* Panel prices are for pooled pricing. Individual WNV NAT is an additional $7.60

DESCRIPTION	SUGGESTED CPT-CODES	ITEM CODE	PRICE ($)
ABO & Rh	86900, 86901	4000 RC	35.70
Allogeneic Adsorption	86971, 86978	4210	204.00
Antibody Identification	86870	4020 RC	97.00
Autoadsorption	86971, 86978	4220	153.00
Chloroquine/EGA Treatment of RBC's	86860	4270	142.75
Compatability Screening	86922	4070	40.75
Direct Antiglobulin Test	86880	4060	46.00
Donor Antigen Test, confirmed per antigen			
– CEceK	86903	4041 UPH	49.00
– AHG	86903	4042 UPH	72.50
– Direct	86903	4043 UPH	79.50
– Rare Low Frequency	86903	4044 UPH	79.50
– Rare High Frequency	86903	4045 UPH	118.25
Saline Replacement	86977	4320	20.50
DTT Treatment of RBC's	86970	4271	71.50
Eluate	86860	4290	132.50
Enzyme Treatment of Panel	86971	4250	66.25
Hemoglobin Screening	85660	4082 UPH	46.00
Microhematocrit/Hypotonic Cell Separation	86972	4280	86.75
Neutralization (HPC/Plasma/ Lewis/ P)	86977	4260	102.00
Patient Antigen Test			
– Rh Phenotye	86906	4031 RC	128.50
– CEceK (individual antigen)	86905	4032 RC	49.00
– AHG	86905	4033 RC	72.50
– Direct	86905	4034 RC	79.50
– Rare Low Frequency	86905	4035 RC	79.50
– Rare High Frequency	86905	4036 RC	118.25
Pre-warm	86940	4230	51.00
Titration	86886	4240	66.25
Triple Adsorbing Cells	86971	4084	61.25
RBC Molecular typing (patient)	83891, 83900, 83901x22, 83892x2, 83912, 83914x22	4115 P	510.00
RBC Molecular typing (donor)		4115 U	153.00
ARDP Fee (per unit)	86999	4105	204.00
Export Fee for Rare units (per unit)	86999	9171	127.50
Import Fee for Rare units (per unit)	86999	9170	127.50
Coordination/Consultation Fee	86999	4120	81.50
STAT Fee, For immediate provision of services Mon -Thur evenings and overnight and Fri evening	86999	4130	255.00
STAT Fee, For immediate provision of services during holidays, Fri overnight, Sat and Sun	86999	4130 N	510.00

The Blood Center Reference Laboratory is available on-site or on-call 24/7 by calling

DESCRIPTION	SUGGESTED CPT CODES	PRICE ($)
ROUTINE ITEMIZED TESTING		
1. HLA Typing (ABC)	83891, 83896x224, 83898x3, 83912	400.00
2. HLA Typing (ABCDRDQ)	83891, 83896x224, 83898x3, 83912	500.00
3. ABO	86900	15.00
4. Autocrossmatch T-Cell Flow	86805 X 6	212.50
5. Autocrossmatch B-Cell Flow	86805 X 6	212.50
6. Crossmatch (Donor T-Cell) Flow	86805X6	212.50
7. Crossmatch (Donor B-Cell) Flow	86805 X 6	212.50
8. Flow Antibody Screen Class I PRA	88184, 88185, 88187	158.00
9. Flow Antibody Screen Class II PRA	88184, 88185, 88187	158.00
10. Antibody Identification Class I	88184, 88185, 88187	350.00
11. Antibody Identification Class II	88184, 88185, 88187	325.00
12. Donor Specific Antibody DSA Class I	88184, 88185, 88187	350.00
13. Donor Specific Antibody DSA Class II	88184, 88185, 88187	325.00
14. SPRCA Crossmatch (HLA or Single Donor) Platelet	86806	165.00
15. Platelet Antibody Screen	86022	200.00
ROUTINE PANELS for Ease of Ordering (See itemized listing for tests included in panel)	**TEST NUMBER** (Routine itemized Testing List)	
Platelet Support Services		
Hematology Profile		1, 3, 10, 15
HLA Class I PRA and Antibody Identification Class I (Flow)		8, 15
SPRCA Crossmatch (HLA or Single donor) Platelet		14
Cardiac/Renal Services		
Transplant Candidate Profile		2, 3, 4, 5, 8, 9, 10, 11
Cadaveric Transplant Donor		3
Living (renal)Transplant Donor Profile		2, 3
Cardiac/Renal Transplant Recipient (day of transplant)		6, 7, 8, 9, 10, 11
Bone Marrow Transplant		
Bone Marrow Transplant Profile		2, 3, 8, 9
Bone Marrow Donor		2
Neonatal Alloimmune Thrombocytopenia (NATP) Panel		10, 14, 15
TRALI Investigation		No Charge for the Blood Center Units

DESCRIPTION	SUGGESTED CPT CODES	PRICE ($)
Other Services		
Platelet Antigen Typing		
Full Platelet Antigen Typing (HPA-1,2,3,4,5,6,15)	83896 x 2,83912	360.00
PLA1	83896 x 2,83912	175.00
Disease Association Profile		
HLATyping (AB/DR/DQ) per antigen	83891,83896x224,83898x3,83912	200.00
Parathyroid Tissue Cryopreservation	60500	850.00
Parathyroid Freezing Solution Sterility Check	87070, 87102	150.00
Parathyroid Tissue Release/Transportation Charges		varies with shipping
Parentage Testing		
Trio (Domestic)		490.00
Trio (International)		550.00
Single Parent Testing (Domestic)		550.00
Single Parent Testing (International)		585.00
Siblingship Testing (each person tested)		300.00
Each additional client		200.00
Specimen Collection Fee (out of state)		37.00

Regular hours are Monday – Friday, 8:00a.m.–4:30p.m. (excluding holidays)
Services outside of these hours will incur an additional STAT charge of $250.00 per order

RECALLS/MARKET WITHDRAWALS

A. In the event that blood products are recalled or withdrawn due to unsuitability, the parties shall comply with the responsibilities regarding notification and other actions to be taken set forth in the Cosignee/Recipient Notification of Recalls/Market Withdrawals, attached hereto as Exhibit A-2, and incorporated herein.

Blood Center:
Initial BBB Date 6-27-13

Client:
Initial GGC Date 7-8-13

EXHIBIT A-2
CONSIGNEE/RECIPIENT NOTIFICATION
OF RECALLS/MARKET WITHDRAWALS

The Blood Center shall notify the Client of recalls and market withdrawals of blood products as soon as possible after discovery of a reactive screening test or other reason for product unsuitability.

I. The Blood Center shall notify the Client as soon as possible, and no later than 72 hours of test completion of any potentially infectious disease marker or other reason for product unsuitability for blood products the Client has received from the Blood Center. For products intended for transfusion, the scope of review will include all of the donor's units collected within the past five (5) years. For products intended for further manufacture into injectable products, the scope of review will include all of the donor's units collected within the past six (6) months.

A. Current positive tests for HIV for donors with prior donations:
- Consignee will be contacted within three (3) calendar days (typically by phone) to determine the disposition of in-date, and thus potentially available, components.
  - HIV ABY repeat reactive lookback extends back 5 years or 1 year prior to the last negative test of record, whichever time is shorter.
  - HIV NAT reactive lookback extends back 12 months from the date of the current reactive test of record.
- Available components are to be returned to IBC for credit.
- Per applicable guidance, consignee will be contacted as soon as possible, and within 45 days, once additional testing is complete and confirms infectious disease markers. Recipient Data Sheets will be utilized to document cases needing Recipient Tracing.
  - Consignees should perform Recipient Tracing per applicable guidance and return Recipient Data Sheets to IBC, Clinical Services within guidance specified time frames (e.g. 45 days from notification receipt).

B. Current positive tests for HCV for donors with prior donations:
- Consignee will be contacted within three (3) calendar days (typically by phone) to determine the disposition of in-date, and thus potentially available, components.
  - HCV ABY repeat reactive lookback extends back 10 years or 1 year prior to the last negative test of record, whichever time is shorter.
  - HCV NAT reactive lookback extends back 12 months from the date of the current reactive test of record.
- Available components are to be returned to IBC for credit.
- Per applicable guidance, consignee will be contacted as soon as possible, and within 45 days, once additional testing is complete and confirms infectious disease markers. Recipient Data Sheets will be utilized to document cases needing Recipient Tracing.
  - Consignees should perform Recipient Tracing per applicable guidance and return Recipient Data Sheets to IBC, Clinical Services within guidance specified time frames (e.g. 45 days from notification receipt).

C. Other lookbacks, recalls, or reasons for Post Donation Information:

- Notifications and recalls will be made similarly as above and in accordance with applicable guidance; however, for recalled products that are no longer potentially available (post-expiration date), written notification using IBC forms (e.g. Post Donation Information Consignee Notification form, Recipient Data Sheet, etc.) will be sent to the transfusion service. If requested, such forms should be returned as soon as possible, and within 15 days to allow for meeting FDA BPDR reporting timeframes.

II. The Client shall have a clearly defined and written policy that ensures recall notifications from IBC are appropriately received and managed per applicable guidance, and that recalled products are not inadvertently distributed for transfusion. The policy shall include identification of the person responsible for performing this activity, how the units are identified as "in quarantine", and how the units are physically separated from the regular blood inventory. The Client shall, upon request, provide the Blood Center with a copy of the written policy.

References:

- 21 CFR §§ 610.46-610.48
- *Guidance for Industry: Nucleic Acid Testing (NAT) for Human Immunodeficiency Virus Type 1 (HIV-1) and Hepatitis C Virus (HCV): Testing Product Disposition, and Donor Deferral and Reentry.* U.S. Department of Health and Human Services, Food and Drug Administration, Center for Biologics Evaluation and Research, May 2010.
- *Guidance for Industry: "Lookback" for Hepatitis C Virus (HCV): Product Quarantine, Consignee Notification, Further Testing, Product Disposition, and Notification of Transfusion Recipients Based on Donor Test Results Indicating Infection with HCV.* U.S. Department of Health and Human Services, Food and Drug Administration, Center for Biologics Evaluation and Research, December 2010.

Blood Center:
Initial BBB Date 6-27-13

Client:
Initial GBC Date 7-8-13

APPENDIX B
TESTING SERVICES

I. AGREEMENT

A. The Blood Center shall provide to the Client one or more of the Testing Laboratory Services, Immunohematology Reference Laboratory Services, or Histocompatibility Laboratory Services set forth in Exhibit A, attached hereto and incorporated herein, upon submission of the appropriate testing request form by the Client and the Client shall pay the Blood Center the service fees set forth in Exhibit A,

II. TESTING PROTOCOL

A. Testing Request Process

1. The Client shall comply with the applicable testing request processes described in the Customer Resource Manual when the Client requests Testing Laboratory Services, Immunohematology Reference Laboratory Services, or Histocompatibility Laboratory Services.

B. Sample Requirements

1. The Client shall collect, label, store, pack, transport and ship all blood samples in accordance with applicable federal, state and local laws and in accordance with the Customer Resource Manual.
2. The Blood Center shall provide packing materials to the Client upon request.

C. Sample Transport

1. The Client shall transport all blood samples in accordance with the Customer Resource Manual.
2. The Client shall pack samples in accordance with federal, state or local regulations and shipping container manufacturers' specifications and requirements for clinical/diagnostic specimens.
3. The Client shall transport samples at refrigerated temperature to the testing laboratory located at Central Indiana Regional Blood Center, Inc., d/b/a Indiana Blood Center,

4. The Client shall pay for all costs for transporting and shipping to the Blood Center or Third Party Laboratories and reimburse the Blood Center for any freight costs incurred by the Blood Center.

D. Sample Integrity

1. The parties agree that that the integrity of the specimen received by the Blood Center dictates the integrity of the results obtained. The parties agree that the Client must properly collect, store, identify, pack, and ship samples to ensure accurate and efficient processing of the samples.

2. The parties agree that the Blood Center shall not be responsible for any delay in processing under the following circumstances:
    a) The sample and supporting documentation accompanying the shipment is incomplete or in a condition not reasonably satisfactory to the Blood Center (or its Third Party Laboratory) in accordance with the guidelines specified in the Customer Resource Manual;
    b) The sample does not contain an appropriate Barcode label as required by the Customer Resource Manual;
    c) The specimen contains incorrect information for sample shipment reconciliation;
    d) Any aspect of sample identification is incorrect or illegible;
    e) The specimen is not the appropriate quantity, type, or age; or
    f) The Blood Center determines, in its sole judgment, that the specimen has not been properly stored.

E. Sample Receipt and Turn-Around Time

1. Upon receipt of a sample from the Client, the Blood Center shall:
    a) Notify the Client of any damaged samples or any inadequate documentation relating thereto promptly after the arrival of a shipment at the Blood Center or its Third Party Laboratory; and
    b) Handle the samples with all due care for as long as the samples are within the Blood Center's control.
2. Upon receipt of a sample from the Client, the Blood Center may, in its sole discretion:
    a) Refuse to perform services hereunder in any instance in which the Blood Center deems that the samples or related documentation are not in reasonably satisfactory condition; or
    b) Refuse to perform services hereunder in any instance in which the Blood Center deems that the sample does not contain an appropriate Barcode label as required by the Customer Resource Manual;
3. The Blood Center shall complete testing, review and reconciliation of records and transmit test results to the Client in accordance with the testing schedules set forth in the Customer Resource Manual for Testing Laboratory Services, Immunohematology Reference Laboratory Services, and Histocompatibility Laboratory Services.
4. The Blood Center shall immediately convey results from any specimen that registers a critical value to the appropriate Client personnel by telephone, facsimile or other electronic means.
5. The Blood Center shall provide the Client with the following technical information for all tests:
    a) Normal values;
    b) Technical method of analysis; and
    c) Specimen requirements, including special handling instructions.
6. The Blood Center shall notify the Client a minimum of 30 days in advance of significant changes in the test protocols, reagents sample volumes or sample types set forth in the Customer Resource Manual.
7. The Blood Center shall not provide STAT testing unless the parties agree in writing upon the terms, conditions, and fees for STAT testing.

F. Test Performance and Procedures:

1. The Blood Center shall perform and cause its Third Party Laboratories to perform the blood testing services and interpret blood test results in accordance with applicable laws, regulations, manufacturer's package insert instructions (except where otherwise approved by the United States Food and Drug Administration (FDA), and use testing procedures at least as stringent as those recommended by the American Association of Blood Banks (collectively the Regulations).
2. The Blood Center shall perform blood testing services with licensed screening and confirmatory tests or, in the absence of licensed confirmatory tests, by a confirmatory test recognized as appropriate by standard of care and standard industry practices.
3. The Blood Center shall use FDA licensed reagents whenever available.
4. The Blood Center shall provide to the Client copies of the package inserts of each of the assays that the Blood Center and any Third Party Laboratories will perform.
5. The Blood Center shall implement any new immunohematology and viral marker tests approved for use in blood banking/screening by the FDA or applicable standards upon written agreement by the parties of the service fees for such new immunohematology and viral marker tests.
6. The Blood Center and the Client shall comply with applicable state reporting requirements with regard to infectious disease markers.

Blood Center:
Initial BBB Date 6-27-13

Client:
Initial CBC Date 7-8-13

APPENDIX X
SERVICES AGREEMENT – COMMITTED VOLUMES
COMMUNITY HOSPITAL SOUTH

I. PURCHASE COMMITMENT

A. Client and the Blood Center shall agree upon Annual Unit Quantity or percent of amount to be purchased under this agreement, which shall be as follows:

Product Unit	Price per Unit ($)	Annual Unit Quantity or % of Annual Purchased Amount
LRC	215.00	2,195
APLT	500.00	160
FP24	50.00	300
CRYO	43.00	0
POOLED CRYO	300.00	16

B. Pricing for the Committed Volume shall be determined on an annual basis, provided, however, the Blood Center may adjust the price if, in any 3-month calendar quarter (i.e., January-March, April-June, etc.), the quarterly purchases by Client are not within five percent (5%) of the quarterly volume as set forth below for the quarter just completed, in which case, pricing shall default to Blood Center list pricing set forth on Exhibit A-1.

	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Total
LRC	557	550	538	550	2,195
APLT	41	40	39	40	160
FP24	76	75	74	75	300
CRYO	0	0	0	0	0
POOLED CRYO	4	4	4	4	16

II. DELIVERY AND TRANSPORTATION

A. Routine delivery. The Blood Center shall provide scheduled delivery one (1) time per weekday (Mon-Fri) at no charge.

B. Additional delivery. Deliveries requested by the Client beyond the routine delivery will be made the most cost-effective way, one way or round trip, depending on the customer need and ability to schedule the delivery for an additional fee of:

One-way fee	$25.00
Round-trip fee	$50.00

C. Emergency Delivery. Emergency delivery fee will be added to the delivery for those orders which require immediate delivery at the then-current emergency rates charged by third-party delivery services plus a reasonable administrative fee.

D. Transfers. Products transferred from the Client will be credited to Client's account at the service fee in effect at the time the product was shipped to the Client. Products transferred to the Client will be invoiced at the Client's current service fee in effect.

III. RETURNS

Red Cells received with 10 days or more remaining before expiration will be given full credit for the Leukoreduced Red Cell product, excluding any additional special services provided for that unit, in the amount of the service fee in effect at the time the product was shipped to the Client. Apheresis Platelets received with 24 hours or more remaining before expiration and resold, will be given full credit in the amount of the service fee paid in effect at the time the products were shipped to the Client in the month following the calendar quarter end. Special order Apheresis Platelets including Irradiated, HLA matched and cross-matched are not eligible for credit.

IV. STANDING ORDERS

Client may establish a written standing order for blood and blood product services. Standing orders submitted to the Blood Center by any client will be filled ahead of additional orders submitted by the Client. Changes in Client's standing order require seven (7) days written notification, provided, however, such changes may only be made one time per calendar month. Client is to submit a standing order to Blood Center within seven (7) days of contract execution.

To assist both client and Blood Center with utilization review, installation of the AIM software is to be included as part of this process.

Blood Center:
Initial BBB Date 6-27-13

Client:
Initial WBC Date 7-8-13

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE NPP#: I-14B1
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH Page 1 of 12
CANCELS: 5/21/13emergent EFFECTIVE: 8/8/13

TITLE: Blood Component Administration

Performed by:
1. Obtain blood components from Blood Bank: RN, LPN, MHC, PSP, PST, AP, SE, EMT-P (competency verified). Nursing may request Security to obtain blood component from Blood Bank.
2. Start Infusion and administer blood products: RN, LPN, NP, CNS

Purpose: To provide guidelines for administering blood components.

Policy Statements:
1. A patient must be identified prior to the administration of any blood product according to **CLN 3017, Identification of Patient, Use of Two Patient Identifiers**. If the patient is able to communicate, ask the patient to state their name and birthdate. Additionally, verification of patient identification will occur by comparison of patient name, birthdate and medical record number on the blood product slip and the EMR to the patient name, birthdate, and medical record number on the patient's armband. If the patient is unable to communicate, nursing will compare the EMR, patient's armband, and blood product information and verify that all are accurate. All information will be an identical match to patient EMR, armband and blood product. If any information is not correct the blood product must be returned immediately to the blood bank.
2. A physician order is required to administer blood components. Blood Consent/Refusal form must be completed for all blood component transfusions, which includes: Red Blood Cells, Plasma, Cryoprecipitate and Platelets. The form should be signed before obtaining the Type and Crossmatch (T&C) or Type and Screen (T&S) blood sample, but must be signed before the blood component is administered. **(Exception: Physician order to administer blood without the patient's consent in an emergency situation. If blood is administered in an emergency without consent, the reason must be documented in the patient's medical record.)** The consent remains in effect during the hospitalization and a new consent is required for each new inpatient admission. A new consent is required when a patient is admitted to or from Behavioral Health or Rehabilitation Hospital or from an outpatient to an inpatient status.
3. IgG or Rh Immune Globulin are not blood components and do not require signed consents before administration.
4. A red Blood Bank Armband (Blood Recipient ID Band) will be placed on all patients who have a T&S/T&C drawn in an outpatient area/Emergency Department, or on all patients who do not have a Medical Record number. The armband must remain on the patient until midnight of the third day after the T&C/T&S specimen was drawn. If present, this armband must be used as a method of identification. If removed during this period, a new T&S/T&C must be ordered and a specimen drawn.
5. Do not obtain blood products from the Blood Bank until a working patient IV is established. (Exception: Emergency Situations.) The physician's order or the RN's judgment regarding the condition of the patient will be used to determine whether or not to interrupt an already existing IV infusion or to start a second IV site to administer the transfusion. If infusing parenteral nutrition, ($D_{10}W$ concentration or greater and/or lipids), or a continuous PCA narcotic, a second IV site must be started. If unable to obtain a second IV site receive orders from physician for possible interruption of other therapies that cannot be given during blood component infusion.
6. If the patient has an arteriovenous (AV) graft or fistula, blood may not be infused through the graft or fistula unless it is during dialysis.
7. A computer generated requisition to obtain blood label with the patient name (first and last), medical record number, and DOB must be presented when picking blood components up from the Blood Bank. Exception: A handwritten label with the patient's first and last name, Medical Record

Number, and DOB may be used if the patient's condition warrants emergency blood administration and a computer label is not readily available. The person picking up the blood component from the Blood Bank (known as the transporter) must be aware which blood component is to be obtained if the patient has multiple blood components ordered. Blood bank personnel are to be informed by transporter which product component is needed. NOTE: If patient has a red armband, the sticker from the red armband must accompany the label with patient's name, DOB and medical record number in order to pick up the blood.

8. Uncrossmatched red blood cells will be given in an emergency situation when a T&C/T&S specimen has not yet been obtained, but T&C must be obtained as soon as possible and sent to Blood Bank. See NPP#I-14,B-2, Blood, Uncrossmatched for additional information.
9. Blood tubing must not hang for greater than four hours. If more than one blood component is infused, the blood tubing must be changed if the infusions are not completed within the four hour time period. No more than four red cell products can be infused through the same blood tubing.
10. **All blood components must be started and be completely infused within four hours from the time the units leave the blood bank.**
11. **If it is necessary to infuse longer than this, prior arrangements must be made with Blood Bank.** Blood Bank will arrange smaller volumes ("aloquets")to infuse if necessary; for example, Pediatric patient or patients with CHF.
12. If the blood component cannot be started upon arrival to the unit it must be returned to Blood Bank as soon as possible to avoid wasting it..
13. Multiple blood components on a single patient can be released to a nursing unit if the patient's condition warrants. Under no circumstances is blood to be stored in a refrigerator on the nursing units. **Coolers will be provided to nursing by the Blood Bank for the storage of multiple units in surgery, critical care areas, ED or transfusions taking place at areas remote to the blood bank. These coolers are for the use of red cells and plasma products. Platelets and cryoprecipitate are stored at room temperature. The coolers are labeled with information stating when the ice in the cooler must be replaced or returned to the blood bank.**
14. For the pediatric patients less than 100 pounds, the physician must order the amount and rate of blood administration. If this is not specifically ordered, the physician must be contacted.
15. Nursing will monitor the patient in the following ways, pre-, during, and post-transfusion:
    a. By checking the specific physician order for accuracy of blood component to be administered before hanging the component.
    b. By obtaining and recording the temperature, pulse and respirations (T-P-R) and blood pressure (B/P) before the start time of the transfusion and the second set of vital signs between the first 10 and 20 minutes of the infusion.
    c. By obtaining patient temperature a minimum of every 30 minutes during the transfusion when clinically indicated for signs and symptoms of a possible reaction.
    d. By obtaining T-P-R and B/P within 15 minutes of completion of transfusion.
    NOTE: If a transfusion takes less than 15 minutes to complete, the 15 minute assessment and the completion assessment may be completed and documented at the same time, the vital signs would be completed in the post transfusion section and the pre transfusion section for the next unit.
16. During the transfusion of all blood components products or upon its completion, if the patient experiences a 2^{0}F increase or more (one degree Celsius) in temperature, or any other sign/symptom of a transfusion reaction, the transfusion is to be stopped. Call the Blood Bank immediately, receive instructions for transfusion reaction work-up and notify physician. The Blood Bank will inform the nurse of the necessary items for a Transfusion Reaction Work-Up. (These include: post transfusion blood bank specimen correctly labeled, yellow copy of the transfusion record form with reaction information completely filled out, all tubing, filters, fluids and blood components used in the transfusion, and the Transfusion Reaction work up order

requisition.) Orders received from the physician and rationale for interventions must be documented.

17. **In the event that the patient dies while receiving a transfusion, perform the following: document on the transfusion record form that patient died, contact blood bank, send all paper work and tubing to the blood bank, and if possible obtain a post transfusion specimen.**
18. No medication is to be added to or administered with blood components. Use only normal saline (0.9% saline) with blood components.
19. All crossmatched blood and T&C/T&S orders will be automatically released at midnight of the 3rd day from when the specimen is collected. Should the patient require blood after this time period, a new order and crossmatched specimen must be obtained. EXCEPTIONS include pre-op T&C and Pre-op T&S which may be extended for 30 days with pre-op questionnaire.
20. A patient refusing to receive blood for religious or other reasons must sign the Blood Consent/Refusal form section. See Corporate Policy CLN:2062, "Blood Transfusions, Refusal Considerations".
21. Patients requiring transportation while receiving a transfusion must have an RN, Perfusionist or physician in attendance. Hand off to the unit of destination must be to an RN, Perfusionist or physician.

General Information:

1. Potential signs and symptoms of a transfusion reaction include: chest pain, back pain, itching, rash, hives, shortness of breath, feeling anxious, increase in temperature greater than or equal to 2 degrees Fahrenheit or 1 degree Celsius from pre-transfusion baseline vital signs or anything out of the ordinary.
2. Patient identification consists of inspection of the identification armband to verify that the name, date of birth and medical record number are the same as on the Transfusion Record Form and the blood component unit label. If a red Blood Bank Armband (Blood Recipient ID Band) present, this armband must be used as a method of identification.
3. Unit(s) identification consists of verification from the blood component unit label, including:
   a. Patient's Name
   b. Medical Record Number or identification number on red blood bank armband(Blood Recipient Identification Band)
   c. Date of Birth (DOB)
   d. Donor number
   e. Blood Type of unit
   f. Blood type of patient
   g. Unit Expiration
   h. Other specifics, for example, irradiated, CMV.
4. T&C/T&S at CHVH, CHN, CHE, or CHS and processed by Mid America Clinical Laboratories is valid for use at all sites listed above. Any patient transferring from any other location needs need a new T&C and T&S drawn.
5. A physician, NP, CNS or Perfusionist may start infusion and administer blood products.
6. It is recommended that intravenous catheter sizes for use in transfusing cellular products, (Red cells and platelets), range from 14 to 22 gauges.
7. All Red Blood Cells received from Indiana Blood Center are Leukoreduced.

Equipment:

1. IV Pole
2. Blood Administration set
   a. Double Y- type blood tubing (Whole Blood, Packed Cells, and FFP, Platelets, Leukocytes, and Cryoprecipitate)

b. 30ml syringe with filter needle (Factor VIII/Factor IX)
3. Blood warmer (optional) is ordered by physician. (Instruction sheet on machine.)
4. Infusion pump if blood component is to be infused through a central line. An infusion pump is optional if a blood component is infused peripherally.
5. 250 ml Normal Saline (0.9% saline)

A. Obtaining T&C or T&S (Type and Cross/ Type and Screen):

1. If T&C or T&S is needed, identify the patient using the two patient identifiers as described in CLN 3017, Identification of Patient, Using two patient identifiers.
2. Obtain specimen by drawing blood in Blood Bank designated vacutainer tube.
3. On the vacutainer pre-affixed label and print **in indelible ink** the following information:
   a. Patient's full name
   b. Patient Date of Birth
   c. Medical Record number
   d. Date, time and phlebotomist's initials
4. Complete collection information on the lab requisition to include:
   a. Date/time of collection
   b. Phlebotomist's initials
   c. Notation that hospital or red blood bank arm band is present when specimen was drawn.
   d. One additional patient identification item listed below
      1.) Patient said name was:_____
      2.) DOB
      3.) Staff identification of patient
5. Place a red blood bank armband (Blood recipient Identification Band) on patients who have had T&C/T&S drawn in outpatient areas or before a Medical Record number is available. Affix the patient ID portion of this armband on to the tube of blood in the presence of the patient.
6. Place specimen, strip of armband numbers if using Identification Band and requisition in plastic bag and deliver to Blood Bank. Blood Bank refuses specimen if:
   a. There is incomplete labeling of specimen including misspelling of any portion of the name, missing medical record numbers including zeros and omission of date/time of collection and phlebotomist's initials.
   b. There is inaccurate labeling of specimen which includes using printed labels for T&C and T&S.
   c. Specimen labeling is not in agreement with requisition.

B.Obtaining Blood Component(s) from the Blood Bank

1. The transporter hands the pick-up slip to the Blood Bank associate at Blood Bank If the patient has a red armband, the sticker from the red armband accompanies the label with patient's name, DOB, and medical record number in order to pick up the blood.
2. The Blood Bank associate retrieves the blood component(s) and dispenses in the laboratory computer.
3. The transporter then reads to the Blood Bank associate the following from the Transfusion Record Form:
   a. Patient Name
   b. Medical Record Number
   c. Date of Birth
   d. Patient ABO/Rh
   e. Unit ABO/Rh
   f. Unit number and correlating red armband number if appropriate
   g. Component
   h. Crossmatch results

i. Unit expiration date and time
j. Comment

4. The transporter then signs the Transfusion Record Form (s) in the area **TRANSPORTED BY** along with the date and time, and the department where the transfusion will take place.
5. The transporter hands the Transfusion Record Form (s) back to the Blood Bank associate to sign in the area marked Technician Issuer
6. The Blood Bank associate removes the pink copy from the Transfusion Record Form (s) and places the Transfusion Record Form, Blood Bag label and blood component in a bag (either paper or plastic) or cooler for transportation to the nursing unit.
7. The Blood Bank associate dates and writes the 4 hour blood product outdate time on the Blood Bag Label sheet and includes this in the bag or cooler for transportation to the nursing unit.
8. Pneumatic Tubing of Blood and Blood Products for NICU and CHVH (weekends only for CHVH):Complete the Blood Pneumatic Tube Transport form (see addendum # 3).
   a. Perform 2 patient Identifiers with physician order before sending form to Blood Bank
   b. If patient has a blood bank band include the number in the space provided on form
   c. Handwrite the patient's full name and birthdate, Medical Number, and Room number
   d. Fill in number of Product Requested :_____
   e. Quanity:_____ Tube Station:_____
   f. Phone:_____Initials:_____
   g. Follow the instructions to "Send request form via pneumatic tube"

2. Blood Bank :
   a. Completes the "Date/Time Product Sent" section of the Blood Pneumatic Tube Transport form and they will retain the bottom (yellow) copy
   b. Notifies the Clinical area that the blood product is being sent.
   c. Places product, Blood bag label dated with the 4 hour blood product outdate time and top copy of transport form in sealed Ziploc bag(s). Place
   d. Ziploc bag into a pneumatic tube.
   e. Blood bank tech calls receiving area if "Blood Pneumatic Tube Transport" form is not returned to the Blood Bank within 15 minutes.

3. Clinical area removes unit from the pneumatic tube system and
   a. compares the information on Unit Compatibility label, Transfusion Record Form and Blood Product Request Form.
   b. Complete the "Receipt" section of the Blood Pneumatic Tube Transport form
   c. Returns the form and the refrigerated gel pack (if applicable), via the tube system to the blood bank.
   d. Two members of the transfusing staff verifies donor unit information per Blood Administration policy, with the transfusion tag and patient wristband information at the patient's bedside.
   e. If there are any discrepancies, the Neonatal Intensive Care Unit (NICU) personnel will **WALK** the unit back to the Blood Bank for resolution. For discrepancies at The Indiana Heart Hospital (CHVH) the staff call the Blood Bank for further instructions.

C. Transfusion

1. Complete bedside verification process using the Transfusion Record Form. Utilizing two 2 staff members, one of which is a licensed professional (RN, LPN, Physician/NP, Perfusionist).Compare -the specific physician order for accuracy of blood component to be administered before hanging the component. Scans the blood bag for the unit number and the product code number.
2. Compare the patient's name, DOB, and medical record number on the identification armband with the patient's name, DOB and medical record number, and if applicable the red armband number on the Transfusion Record Form and the blood component unit label.

3. Compare the unit number, ABO group, and Rh on the blood component unit label with the unit number ABO group, and Rh on the Transfusion Record Form. Contact Blood Bank immediately for any discrepancies.
4. Obtain baseline Respirations, Pulse, Temperature and B/P immediately prior to transfusion. If patient's temperature is 101^{0}F or above, notify the physician prior to starting the blood component and receive orders.
5. Attach blood component to prepared IV tubing.

Infuse at:

Component	1st 15 minutes	After 15 minutes	Pediatric
Red Blood Cells	75 ml/hour	150 ml/hr	2-5mL/kg/hr
Plasma	NA	200-300ml/hr	60-120 mL/hr
Platelets	30ml/hr	200-300mL/hr	60-120mL/hr
Cryoprecipitated AHF	As Rapidly as Tolerated		As Rapidly as tolerated

6. The RN observes the patient closely, assessing and monitoring the patient for the first 15 minutes after the transfusion is started to observe for potential signs and symptoms of a transfusion reaction.
7. Between the first 10 and 20 minutes of the infusion, obtain vital signs including temperature, pulse, respiratory rate, and blood pressure and document the complete vital signs on the Transfusion Record Form. Observe the patient for shaking, chills, pain, nausea, itching or other symptoms and document. If the patient's condition is satisfactory, the rate can be increased to that listed in the table above.
8. Continue to monitor and assess the patient intermittently throughout the transfusion.
9. If a unit of blood has been infusing for more than 4 hours, discard remaining blood in red biohazard containers in dirty utility area and completely change all IV tubing that was used for transfusion.

D. Post Transfusion:
1. After transfusion is complete, flush blood tubing with normal saline, then discard all blood tubing, bag and supplies from transfusion in red biohazard container in dirty utility area.
2. Resume previous IV fluids. If IV site may be needed for additional transfusions, then maintain as a PIV lock.
3. Take post-transfusion vital signs (T-P-R & BP) within 15 minutes of completion of the transfusion and record on the Transfusion Record Form.
4. Review and verify Transfusion Record Form is complete with all appropriate signatures, dates and times. Unlicensed personnel may collect vital sign data; however, all vital signs must be reviewed and initialed by the RN. Place original in chart and send yellow copy to Blood Bank via pneumatic tube . If no access to pneumatic tube send via interdepartmental mail .

E. Transfusion Reaction
1. Stop the transfusion immediately if any symptoms of a reaction occur. Immediately switch from blood infusion to saline and get specific treatment orders for reaction from physician. Mild urticaria, hives, or an increased of temperature less than 2^{0}F (or 1^{0}C) alone may not be deemed a sufficient indication by the physician to discontinue the transfusion. All other symptoms require the stopping of the transfusion and proceeding with steps 2, 3 ,4 and 5.
2. Immediately, visually check the patient armband, blood product unit label and transfusion record form, to verify that this is right patient, right blood product, right patient medical record number, and that all information matches the patient arm band, blood component unit label and the Transfusion Record Form.
3. Call the Blood Bank for instructions on proceeding with a transfusion reaction work-up.

4. Order a transfusion reaction work up. Complete and sign the Transfusion Record Form and return yellow copy of the Transfusion Record Form and the blood component bag with all blood tubing, tags and fluids to the blood bank (place in biohazard bag for transport from patient unit to the blood bank.) Transfusion Reaction Record is completed by the Blood Bank. Nursing to document in the EMR.
5. For general information regarding specific transfusion reaction, see addendum. There is the possibility of delayed hemolytic reaction. This type of reaction most frequently occurs between 3-14 days post-transfusion.
   a. **Transfusion Associated Circulatory Overload (TACO)**
      Definition: Infusion volume that cannot be effectively processed by the patient either due to the high infusion rate and /or volume or an underlying cardiac or pulmonary pathology
      Signs and Symptoms: New onset of exacerbation of ≥ 3 of the following within 6 hours of transfusion:
      Acute respiratory distress (dyspnea, orthopnea, cough)
      Evidence of positive fluid balance
      Elevated brain natriuretic peptide (BNP)
      Radiographic evidence of pulmonary edema
      Evidence of left heart failure
      Elevated central venous pressure (CVP)
   b. **Transfusion Related Acute Lung Injury (TRALI)**
      Definition: Acute hypoxemia with PAO2/fraction of inspired oxygen [FIO2)] ratio of 300mm HG or less combined and chest e-ray showing bilateral infiltrates in the absence of left atrial hypertension (ie, circulatory overload)
      Onset of TRALI is abrupt in association with transfusion
      Signs and Symptoms:
      No evidence of Acute Lung Injury (ALI) prior to transfusion
      Acute Lung Injury onset during or within 6 hours of transfusion
      Hypoxemia defined by any of these methods:
      PaO2/FIO2 ≤ 300mm Hg
      Oxygen saturation is < 90% on room air
      Other clinical evidence:
      No evidence of left atrial hypertension (i.e. circulatory overload)
      No temporal relationship to an alternative risk factor for Acute Lung Injury during or within 6 hours of completion of transfusion
   c. **Transfusion Associated Dyspnea (TAD)**
      Definition: Respiratory distress within 24 hours of transfusion that does not meet the criteria of TRALI, TACO or allergic reaction. Respiratory distress should not otherwise be explained by a patient's underlying or pre-existing medical condition.
      Signs and Symptoms:
      Acute respiratory distress and occurs within 24 hours of transfusion and TRALI, TACO and allergic reaction and other underlying medical conditions ruled out.

Documentation – Complete the following:

1. Transfusion Record Form
   a. Signatures of personnel starting and stopping transfusion
   b. Signature of personnel verifying patients identity
   c. Date/Time started
   d. Date/Time stopped
   e. Vital signs **before the transfusion starts**, between the first 10 and 20 minutes of the transfusion and within 15 minutes after the transfusion is complete.

f. Consent signed Yes/No
g. If the patient is an infant has the infant blood screen been drawn? Yes/No
h. If blood or blood product is given under anesthesia check the box "□ Given Under Anesthesia see Anesthesia Record". This will direct healthcare providers to vital signs recorded by anesthesia to avoid duplication.

2. EMR on Blood Flow sheet
   a. Document time when unit was hung.
   b. Document normal saline use.
   c. Vital signs recorded at appropriate times as described above
3. Document any patient responses, treatments or further care that is not within normal limits.

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Community Health Network Transfusion Committee 2011

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Standards for Blood Banks and Transfusion Services, AABB, 27th Edition, 2011
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Approved by:	IV NPP Committee	Date:	3/2013
	Infection Control	Date:	5/2013
	Risk Management	Date:	5/2013
	Network Blood Management Officer	Date:	2/2013
Approved:	NPP Steering Committee	Date:	6/12/13

ADDENDUM 1

Complications From The Transfusion of Blood/Blood Products

1. **Hemolytic Reaction: Immediate**
   a. **Causes:** The patient receives red cells that are ABO incompatible, this results in the hemolysis of red blood cells. It happens most often due to a mismatch of blood rather than a crossmatching problem. The severity of reaction correlates with the amount of blood transfused.
   b. **Symptoms:** Fever, chills, pain the lower back/legs, chest tightness, dyspnea, nausea, vomiting, flushing, tachycardia, bleeding from a wound/IV site, feeling of impending doom.
   c. **Blood Products:** Whole Blood, Packed Cells, leukocyte reduced RBC's, washed RBC's, and deglycerolized RBC's.
2. **Hemolytic Reaction: Delayed**
   a. **Causes:** Patient develops RBC's antibody due to transfusion, the antibody hemolyzes RBC's that are incompatible.
   b. **Symptoms:** In the hospital, this will be detected as a decrease in HgB/Hct or an increase in bilirubin due to hemolysis of the incompatible red cells. You will usually not see the immediate, acute signs and symptoms.
   c. **Blood Products:** Whole Blood, Packed Cells, and all RBC products.
3. **Nonhemolytic Febrile Reactions**
   a. **Causes:** Leukoagglutinins react with WBC's. cytokines in donor plasma or bacterial contamination.
   b. **Symptoms:** Fever, chills, nausea, vomiting, headache, dyspnea.
   c. **Blood components:** RBC products, Platelets, FFP.

   Nonhemolytic allergic reaction:
   a. Causes: IgE antibodies
   b. Symptoms: Urticaria, pruritis, erythema, asthmatic symptoms, anaphylaxis, dyspnea and/or laryngeal edema.
   c. Blood Components: All products containing plasma including RBC products, platelet products, fresh frozen plasma, and Cryoprecipitate.
4. **Bacterial Contamination**
   a. **Causes:** This is a rare complication caused by bacteria in the donor blood, usually gram - negative organisms. Immunocompromised patients are at a high risk.
   b. **Symptoms:** Chills, fever, vomiting, abdominal pain, hypotension, shock.
   c. **Blood Products:** Whole Blood, Packed Cells, Platelets, Plasma, and Cryoprecipitate.
5. **Transmitted Diseases**
   a. **Causes:** HIV, Viral hepatitis, human te cell lymphocyte te virus I/II, syphilis, malaria, babesiosis, etc.
   b. **Symptoms:** Onset delayed, disease dependent.
   c. **Blood Products:** RBC products, Platelets, Plasma, and Cryoprecipitate.

ADDENDUM 1 PAGE 2

Complications From The Transfusion of Blood/Blood Products (continued)

6. **Circulatory Overload**
   a. Causes: The volume or rate of infusion exceeds the circulatory system's capacity. Usually seen in patients with underlying cardiac, renal or pulmonary disease; elderly or very young; or massive transfusion (defined as 10 or more units of blood in a 24-hour period.) The possibility of overload can be decreased by the use of packed cells rather than whole blood, an infusion pump and slow rate of infusion, and administration of diuretics as ordered, and transfusion of patients in an upright position.
   b. Symptoms: Usually have gradual onset and correlate with the amount of fluid infused; dysopia, cough, pulmonary congestion/edema, neck vein distention, tachycardia, peripheral edema.
   c. Blood Products: RBC Products, platelets, Plasma.
7. **Pulmonary Embolism**
   a. Causes: Air, clot or foreign material entering the bloodstream via the tubing. Blood filters aid in prevention of emboli.
   b. Symptoms: Sudden chest pain, dyspnea, cough, hemoptysis, anxiety, and hypotension.
   c. Blood Products: RBC Products, Platelets, Plasma, and Cryoprecipitate.
8. **Hypothermia**
   Blood is stored between 1-6° C (33-43° F) compared to a person's blood with a normal temperature of 37° C. The rapid infusion of large quantities of cold blood especially through a central catheter directly into the right atrium can cause a patient to become hypothermic and result in decreased heart rate, blood pressure, cardiac output, coronary blood flow and ultimately cardiac arrhythmia's and arrest. The use of a blood warmer should be strongly considered with these patients.
9. **Acidosis**
   An anticoagulant solution, usually Citrate-Phosphate-Dextrose (CPD), is added to the blood as it is collected. The pH of CPD solution is 5.6, but the buffering action of Whole Blood (7.4) produces a final pH of 7.1 in freshly donated blood. As blood is kept in storage, despite the hypothermic conditions, anaerobic metabolism occurs with the end products being lactic and pyruvic acids. Thus, blood stored for two days has a pH of 6.9 and continues to decrease to 6.5 after 14 days of storage. The low pH of stored blood usually causes no difficulty because it is diluted with the patient's own blood.
10. **Citrate Toxicity and Hypocalcemia**
    The citrate added to stored blood is a calcium-binding agent to prevent coagulation during storage. Normally the excess citrate is metabolized in the liver and excreted in the urine. Toxic levels of citrate accumulate when this process is ineffective because of impaired hepatic and/or renal function, or in massive transfusion. The additional citrate binds ionized calcium in the recipient's blood, which can lower the serum ionized calcium level to the point of depressed cardiac contractility.
11. **Hyperkalemia**
    Potassium levels in stored blood rise gradually as potassium is released into the plasma by red cells lysis. The American Association of Blood Banks reports that the average amount of Potassium in one unit of 21-day old Whole Blood is 4mEq. This does not normally cause problems, except rarely in patients with impaired renal function.

ADDENDUM 3

BLOOD PNEUMATIC TUBE TRANSPORT

Mid America Clinical Laboratories
Indianapolis, IN 46219

REQUEST	RECEIPT
Patient Information: Full Name, MR#, Room #, or Addressograph BB ID #, if applicable_____	I have received the ordered products and have verified acceptable condition. Initials _____ Date/Time _____
Product Requested: _____ Quantity: _____ Tube Station: _____ Phone #: _____ Initials: _____ Send request form via pneumatic tube.	IMMEDIATELY UPON RECEIPT OF PRODUCT, RETURN THIS COMPLETED FORM TO BLOOD BANK VIA PNEUMATIC TUBE.
Date/Time Product Sent: _____ To be completed by Blood Bank If requested product is not received within 30 minutes, call the Blood Bank.	

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COMMUNITY HOSPITALS OF INDIANA, INC.

1500 N. RITTER AVENUE
INDIANAPOLIS, IN 46219

INSTRUCTIONS TO PATIENTS RECEIVING BLOOD OR BLOOD COMPONENT TRANSFUSIONS

Your physician has requested that you be transfused with a blood product. While the great majority of blood transfusions are accomplished without complications, a small number of persons who receive blood may experience one or more of the following symptoms within a few hours of receiving the blood product:

1. Hives
2. Itching of skin
3. Redness or flushing of skin
4. Fever or chilling sensation
5. Shortness of breath
6. Very dark or black urine

These symptoms will usually disappear in a matter of hours but report them to your physician as soon as possible.

During the next 2-3 months, if you develop any onset of fever/chills, fatigue, aching pains, or yellow skin color please contact your physician. Any other change in your condition should also be reported right away.

The symptoms above may not be a complete list of possible adverse effects of blood transfusions. You should call your physician regarding any other problem or symptom.

Date:_____

Signature: _____

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Community Health Network

CORPORATE CLINICAL POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] TIHH
CANCELS: 8/30/09

NPP#: I-14, B-02
Page 1 of 2
EFFECTIVE: 5/23/12

Approved For:
☒ CHE ☒ CHN ☒ CHS ☒ TIHH

TITLE: **BLOOD, UNCROSSMATCHED**

Performed by: RN, LPN, Administrative Partner, EMT-P, EDCT, PSP And PST

Purpose: To outline the process for obtaining blood and blood products before completion of crossmatch testing.

Policy Statements:

1. The record will contain a signed statement from the ordering physician indicating that the clinical situation was sufficiently urgent to require release of blood.

General Information:

1. Blood Bank never releases red blood cells solely on a blood type based on a historical record.
2. The Blood Bank stock O-Rh-negative red blood cells for emergency release.
3. The blood bank stocks AB or A plasma for the emergency release of plasma.
4. If O Rh-negative red blood cells are unavailable, then O Rh-positive red blood cells may be used after consultation with the Blood Bank Medical Director and/or attending physician.
5. If the ABO of the patient is determined before compatibility testing is completed, the Blood Bank will switch to ABO compatible components.
6. The Blood Bank Medical Director and the attending physician are notified by Blood Bank immediately of any abnormal testing results that may affect patient safety.

Equipment: None

Procedure:

1. Request Emergency Release of Blood when the physician deems that the need for blood and blood components is necessary prior to the completion of compatibility testing
2. Place order in the computer for blood products requested.
3. Obtain specimen for crossmatch as soon as possible.
4. Call the Blood Bank and inform them for the need for Uncrossmatched blood and give the following information (if available)
   A. Patient name
   B. Patient date of birth
   C. Medical Record Number
   D. Physician's Name

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E. Number of units requested.

3. Obtain the number of requested units from the Blood Bank along with the transfusion record form. NOTE: Each has a bright orange Uncrossmatched label on each unit of blood.
4. Obtain physician signature for the transfusion of Emergency Release.
5. Administer blood per Blood Administration Policy I-014 B-01, "Blood Component Administration".
6. Place original copy of the Transfusion Record Form on the patient's Medical Record Chart and return the 2nd copy to Blood Bank.

Documentation Guidelines:
Document blood administration in electronic medical record and complete Emergency Release Transfusion Record Form

References: Standards for Blood Banks and Transfusion Services, AABB, 27th Edition, 2011
AABB Technical Manual, 17th Edition, 2011

Approved by:	IV Advanced Practice	Date: 4/30/12
	Risk Management	Date: 3/21/12
	Infection Control	Date: 2/29/12
Approved:	NPP Steering Committee	Date: 5/9/12

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BB.Issue.1.0 Emergency Release of Blood Components

STATEMENT OF PURPOSE

To outline steps to be taken for release of:

a) Uncrossmatched red cells in an emergency situation;
b) Release of plasma and platelet products when an ABO/Rh type is not available.
c) Product selection for Neonatal Emergency Release.

SCOPE

This document applies to all Mid America Clinical Laboratories Blood Banks.

RELATED DOCUMENTS

BB.ABO/Rh.1.0	ABO Blood Grouping
BB.ABO/Rh2.0	Rh testing – D and Weak D
BB.IAT/DAT.1.0	IAT – Indirect Antiglobulin Testing
BB.TYSC/TRBC.1.0	Compatibility Testing – Required Testing
BB.Issue.2.0	Dispensing of Blood Components
BB.TYSC/TRBC.6.0	Selection of and Indications for Products for Transfusion
BB.Issue.8.0	Preparation of Emergency Release Container

SPECIMEN

EDTA or Clot tube as described in BB.Spec.1.0

MATERIALS

Emergency Release Container in BB refrigerator:

- 2 to 4 units of O negative red cells
- TRF with completed Emergency Release Block
- Orange Uncrossmatched Blood stickers
- Labeled segments from each issued unit
- Optional: Make a Xerox copy of each unit label in the container to scan when the emergency release units are allocated and issued after crossmatch is complete.

PROCESS

I. Neonatal Emergency Release

In the event that blood is need emergently for a neonate, the following product will be released:

- O negative
- Irradiated
- CMV negative
- Freshest unit available, preferable less than 5 days.
- If irradiated and or CMV negative blood is not available, contact the transfusion physician on possible product substitution, as in CVM not required due to red cells being leukoreduced.

II. MACL Staff Available

A. Blood Product Selection

1. Based upon available history, if the patient has special needs, then immediately consult Medical Director/pathologist on call. If history indicates patient has antibodies, notify ordering physician immediately of unavailability of compatible product. However, DO NOT REFUSE to give potentially incompatible product if warranted.
2. Each Blood Bank will routinely stock at least 2 units of O negative red cells for Emergency release.
3. If O negative blood is unavailable, do not delay releasing blood, but issue O positive red cells
4. O positive blood should not be given to women less than 55 years of age or pediatric patients unless Medical Director and/or patient's physician have been consulted
5. **NEVER** give Red Cells Products based on historical type.
6. If the contents of the Emergency Release Container are transfused, the container needs to be restocked at the earliest time possible. See BB.Issue.8.0 Preparation of Emergency Release container.

B. Emergency Release No Specimen Available

Step	Action	Notes
1	Receive call requesting uncrossmatched blood.	
2	Request: Patient name MR# Transfusing physician Number of units	Patient information may not always be available. In emergency situations gather as much identifying information as available.
3	State need for blood bank specimen as soon as possible.	

4	Remove either of the following: • Emergency Release Container • 2 units of either O neg or O positive blood (dependent on the age and sex of the patient)	See BB.ISSUE.8.0 Preparation of Emergency Container.
5	Write available patient information on orange "Uncrossmatched Blood For" label on each unit.	Must include at least patient name and MR# if available.
6	Complete Emergency Release Block of the Transfusion Record Form.	
7	Prepare units for transport in blood box, if utilized.	Use of box is preferable, but not mandatory in an emergency.
8	Issuing tech signs "Issued By" line of Emergency Release Block.	
9	Transporter brings documentation of patient to received Emergency Issued product.	Documentation should be as much information as is available at the time of release, i.e. Name: John Doe MR#: if available BBID: if used
10	Perform read back procedure for the issue of blood between transporter and blood bank associate. • Any patient information that is available • Unit number • Unit type • Exp. date	
9	Emergency release to a transporter: a. Transporter signs "Transported By/Received By" line of Unit Transportation Block. b. Retain bottom copy of Transfusion Record Form. c. Send top 2 copies of Transfusion Record Form with unit(s).	Transporter is defined as an appropriately trained MACL or hospital employee. Use copy to help track units and documentation of physician signature.

C. Emergency Release – Specimen Available

Step	Action	Notes
1	Receive call requesting uncrossmatched blood.	
2	Request the following information: Patient name MR# Transfusing physician Number of units	Patient information may not always be available. In emergency situations gather as much identifying information as available.

4	Select type specific red cells if there is current TRBC or TYSC order.	• A current specimen is one drawn within the last 3 days. Order as additional red cells. • Perform an eXM if IAT is negative. • If patients requires AHG crossmatch, contact pathologist and/or attending physician with patient's history.
6	If antibody screen was positive, or patient has a history of positive antibody screen, retain one segment from each unit. Label segment with unit number.	
7	Complete "Emergency Release Block" of Transfusion Record Form.	Up to 4 units may be initially released. **(Exception:** Surgery may be given more depending on circumstances.)
8	Write available patient information on orange "Uncrossmatched Blood For" label on each unit.	Must include at least patient name and MR# if available.
9	Place orange "Uncrossmatched Blood For" label on each unit.	
10	Prepare units for transport in blood box, if utilized.	Use of box is preferable, but not mandatory in an emergency.
11	Issuing tech signs "Issued By" line of Emergency Release Block.	
12	Transporter brings documentation of patient to received Emergency Issued product.	Documentation should be as much information as is available at the time of release, i.e. Name: John Doe MR#: if available BBID: if used
13	Perform read back procedure for the issue of blood between transporter and blood bank associate. • Any patient information that is available • Unit number • Unit type • Exp. date	
14	Emergency release to a transporter: a. Transporter signs "Transported By/Received By" line of Unit Transportation Block. b. Retain bottom copy of Transfusion Record Form. c. Send top 2 copies of Transfusion Record Form with unit(s).	Transporter is defined as an appropriately trained MACL or hospital employee. Use copy to help track units and documentation of physician signature.
15	Upon completion of testing: • Enter testing results in computer • Dispense units in the computer • Unit comment:";ISUN"	ISUN = Units issued Uncrossmatched.

D. Emergency Release – Testing and Paper Work Completion

Step	Action	Notes
1	**Perform** ABO/Rh immediately upon receipt of a properly labeled specimen.	If unable to obtain specimen due to patient demise, enter comment in patient history (e.g., "Patient specimen never received for crossmatch.") See computer steps.
2	**Perform** antibody screen. If negative, **allocate** units and **electronically crossmatch** emergency released units. Notify floor of completed antibody screen results.	If additional units are ordered, select ABO compatible units and continue with electronic crossmatch.
3	**--If positive antibody screen results are obtained, notify requesting physician immediately.** **--If physician wishes to continue with the transfusion, ensure yellow copy of transfusion record form has been signed by that physician.** **--If physician decides to continue transfusing, perform gel crossmatch using segments from units that were emergency released.** **--If crossmatch incompatible, notify physician IMMEDIATELY.** **--Proceed with antibody identification.**	**"Contact Supervisor/Designee and Medical Director."** **Enter** a BBCMT comment to indicate name of physician called, date, time, and initials of tech entering comment. **Write** same comment on the requisition: name of physician notified, date, time and initials of tech doing the notifying.
4	**Verify** that a type and crossmatch has been ordered.	
5	**Receive** orders.	
6	**Record** patient results in the computer.	
7	**Discard** printed Transfusion Record Forms after allocation of units and crossmatch results are entered.	**Hand written Transfusion Record Form is the permanent record.**
8	**Issue units in the computer in Blood Product Issue Function:** At the **"Issue Comments" field** (within Issue Information Area): **Type ISUN** **TAB (ISUN populates with Issued Uncrossmatched).**	See BB.Issue.2.0 Dispensing of Blood Components.
9	Paper work follow up: • Keep pink copy in view for reminder of follow up till yellow copy received from nursing unit. • Obtain yellow copy of Transfusion Record Form with physician's signature. • File yellow copy in blood file labeled "Emergency Release.	When finalized, one copy should be retained on patient's chart (white copy). Signed yellow copy is retained in blood bank for at least one year. (Permanent record in patient's chart.)

II. MACL Staff Unavailable – Sites without staffing 24/7

NOTE: Red cell products shall be made accessible for emergency transfusion at all MACL hospital based lab sites that are not staffed continuously. These blood products must be easily identifiable by non MACL staff and must be labeled appropriately. The necessary accompanying paperwork should be stored with the red cells.

A. Blood Product Selection and Release – Utilizing Emergency Release Container

Step	Action	Notes
1	Patient requires emergency transfusion at a time when the laboratory is not staffed.	
2	An appropriately labeled blood bank specimen should be obtained on the patient prior to transfusion.	
3	An order for crossmatch must be placed in the hospital computer system.	
4	Nurse or physician enters blood bank area and removes the "Red Cells for Emergency Transfusion" container from the blood bank refrigerator.	
5	Following the "Nursing Instructions for Emergency Transfusion", the blood transporter (nurse or physician) completes the indicated portion of the Transfusion Record Form.	
6	Transporter (nurse or physician) fills out patient information on the orange "Uncrossmatched Blood For" label.	
7	Transporter (nurse or physician) takes top two copies of the Transfusion Record Form with the units and leaves the bottom copy for the laboratory staff.	
8	Transporter (nurse or physician) will obtain the ordering physicians signature in the appropriate area of the Transfusion Record Form. The signed copy MUST be returned to the blood bank.	
9	Units that are not transfused must be returned to the blood bank refrigerator within 30 minutes. Accompanying paper work must also be returned.	

B. Emergency Release Specimen Work Up by MACL Staff

Step	Action	Notes
1	Perform blood type, antibody screen and crossmatch testing on the pretransfusion specimen.	Send the specimen to CTS if staff is not present to perform testing.
2	Notify patient care area of the results when testing is completed.	

3	Discard the Transfusion Record Forms that are generated during result entry If the units have been transfused. **The handwritten Transfusion Record Form is the permanent record.**	If the units have been returned to the blood bank, they may be relabeled with the computer generated Transfusion Record Forms.
4	**Issue any transfused units in the computer in Blood Product Issue Function:** At the **"Issue Comments" field** (within Issue Information Area): **Type ISUN** **TAB (ISUN populates with Issued Uncrossmatched).**	
5	Obtain the yellow copy of the Transfusion Record Form that is completed with the physician's signature documenting the emergency release. File appropriately.	When finalized, one copy should be retained on patient's chart (white copy). Signed yellow copy is retained in blood bank for at least one year. (Permanent record in patient's chart.)

III. Plasma or Platelet Products

- If MACL staff is unavailable, patient care staff follows "Nursing Instructions for Emergency Transfusion".

Step	Action	Notes
1	Receive call requesting plasma products.	FFP, Cryo or Platelets
2	Request: Patient name MR# Transfusing physician Number of units	Patient information may not always be available. In emergency situations gather as much identifying information as available.
3	Perform history check, if no historical type is available, issue the following: **FFP- type AB** **Platelets – any type available** **Cyroprecipitate- A or O**	**NOTE: Up to 500 mls of incompatible plasma may be given in 24 hours without notification of Medical Director.**
4	State need for blood bank specimen as soon as possible.	
5	Upon receipt of properly labeled specimen, perform blood type and proceed with giving type compatible products.	

COMPUTER STEPS

1. Completing Sample Testing Results in Function Blood Order Processing after Emergency Issue

Step	Menu Selection	Action	Notes
1.	Blood Order Processing	Enter patient's MR# in the "Value" field and select appropriate patient.	M# must be entered from patient's specimen tube.
2.		Select Order Selection tab.	
3.		Select accession number.	
4.	Patient Specimen	Perform and enter patient test results.	See computer steps in BB.ABO/Rh.1.0 ABO Blood Group Testing BB.ABO/Rh.2.0 Rh Testing- D and Weak D BB.IAT/DAT.1.0 IAT-Indirect Antiglobulin Testing. **If unable to obtain specimen due to patient demise, order BBCMT in "add spec. test" field. Free text ; Patient specimen never received for crossmatch. Add date and initials of tech commenting.**
5.	Allocation	Press **Allocation tab.** Place cursor in **Unit #** field. Enter unit number of each unit issued. Sites that make a copy of emergency kit unit labels will be able to scan the unit number from the Xerox copy. Press **Select.**	Perform crossmatch methodology required for patient. BB.TYSC/TRBC.1.0 Compatibility Testing – Required Testing BB.TYSC/TRBC.2.0 Electronic Crossmatch BB.TYSC/TRBC.3.0 Crossmatch - IS BB.TYSC/TRBC.4.0 Crossmatch- AHG
6.		Click on **Save** button.	

REFERENCES

Standards for Blood Banks and Transfusion Services, AABB, Current Edition.
AABB Technical Manual, Current Edition.

WRITTEN BY: Pat Smith, MT (ASCP)

IMPLEMENTATION DATE: January, 2000

BB.TYSC/TRBC.6.1 NURSING GUIDE FOR RED CELL SUBSTITUTUIONS

The following explanation may be sent with red cell units that are non ABO/RH identical.

Whenever there is a blood shortage from our blood suppliers (Indiana Blood Center or American Red Cross), the possibility exists that patients may receive a unit different from their own blood type. The following chart lists the acceptable blood type substitutions.

Red Cell Product Transfusion

A. Substitution Table - **ABO**

Patient Type	Acceptable ABO TYPE
O	O
A	A, O
B	B, O
AB	AB, A, B, O

B. Substitution Table – **RH**

Patient Type	Acceptable Rh TYPE
Rh positive	Rh positive or Rh negative
Rh Negative	Negative OR positive if inventory warrants with the following guidelines:
	1. Patient is a male 2. Female older than 55 years of age or consent has been obtained from the Medical Director. 3. Patient does not have the Anti-D antibody.

BB.Recv.4.0 OBTAINING BLOOD COMPONENTS

STATEMENT OF PURPOSE

The purpose of this document is to outline the process for ordering blood components from suppliers.

SCOPE

This process applies to all Mid America Clinical Laboratory Blood Banks.

RELATED DOCUMENTS

BB.Gen.2.0	Minimum Inventory (Site Specific)
BB.Recving.1.0	Receipt, Inspection, Storage and Disposal of Blood Components and Reagents
BB.Misc.5.0	Indiana Blood Center Critical Policy

PROCESS

Standing Orders are established for all hospital sites with our blood suppliers. These standing orders apply to red cell and platelet products. Standing order blood components for sites in the Indianapolis area will be delivered to the CTS (Centralized Transfusion Service) for processing and distribution to hospital sites. Standing orders may be altered by either CTS or the respective hospital site when inventory needs change.

If a site hospital changes a standing order scheduled to be delivered to CTS, CTS is to be notified of the change. If CTS does not receive a scheduled standing order, they notify the site hospital.

When red cell products or platelets are needed immediately, the hospital site should contact the blood supplier directly and have the blood product delivered directly to the hospital site.
Plasma products and cryoprecipitate should be ordered by and delivered directly to the hospital site.

I. Placing Orders with IBC (Indiana Blood Center)

Step	Action	Notes
1	Phone distribution department,	

2	When placing the order, the following information will be given: • Callers name • Facility's name • Product needed • ABO/Rh type needed • Number of units for each product/type needed. • Type of special run o Express: Orders are filled and picked up from IBC within 1 – 1 ½ hours from time order is placed o Stat: Stat orders will be filled and picked up from IBC within thirty (30) minutes form the time the order is packed or delivered immediately following packing into IBC STAT car. o Standard: Standard orders have a three hour window form pickup to delivery.	
3	Document order on Blood Supply Order Log, (BB.Recving.4.1) or any other documentation method.	
4	In the event of a disaster, IBC will make every effort to maintain the blood supply to its customers.	

Placing Orders with ARC (American Red Cross- Fort Wayne)

Step	Action	Notes
1	Phone distribution departmer	
2	Place order.	State how and when shipment is to be made, i.e., Stat, routine.
3	Document order on Blood Supply Order Log.	
4	In the event of a disaster, ARC will make every effort to maintain the blood supply to its customers.	

Placing Orders with ARC (American Red Cross- Louisville)

Step	Action	Notes
1	Phone distribution departmen	
2	Place order.	State how and when shipment is to be made, i.e., Stat, routine.
3	Document order on Blood Supply Order Log.	
4	In the event of a disaster, ARC will make every effort to maintain the blood supply to its customers.	

REFERENCES

IBC Disaster Plan for Blood Product Supply.
IBC Blood Services Guide.
ARC Disaster Plan for Blood Product Supply.

WRITTEN BY: Kim Coors, MT (ASCP) BB

IMPLEMENTATION DATE: April 2000

BB.GEN.8.0 Verbal Orders for the Provision of Blood Components

STATEMENT OF PURPOSE

During emergent situations, there may be times when the entry of orders into the hospital order system may not be able to be completed in a timely manner. During these rare times, the blood bank may take verbal orders over the phone. After the crisis situation has been resolved, the nursing unit along with the ordering physician will ensure that written/electronic orders are sent to the blood bank per CLIA regulations. (42CFR 493.1241(c))

The purpose of this document is to outline the steps necessary to take when receiving verbal orders for the provision of blood components.

SCOPE

This protocol pertains only to Mid America Clinical Laboratories Blood Banks.

RELATED DOCUMENTS

BB.GEN.8.1 Verbal order form

PROCEDURE

The procedure for receipt and processing of verbal orders from surgical areas will be as follows:

I. Receipt of the verbal order:

A. Associates answering the phone in the blood bank will take the following information and document on the Verbal order form BB.GEN.8.1:

1. Patient's full name
2. Medical Record number
3. Blood Bank ID number if applicable
4. Patient's date of birth
5. Ordering physician's first and last name
6. Name of person giving the verbal order
7. Location
8. Component(s) being requested
9. Number of units requested for each component type.

B. Placing orders into Sunquest:
   1. In function REH, place the order for each component ordered and the amount requested
   2. Place the Sunquest order labels on the Verbal Order form BB.GEN.8.1

C. Processing the orders:
   Orders will be processed in Misys in the standard manner.

D. Follow up:
   1. Upon the completion of the case, the OR team will place the orders in the hospital order system.
   2. The blood bank associate will take the printed order requisition(s) from the printer and attach to the Verbal Order Form BB.GEN.8.1.
   3. The printed orders will be retained in the blood bank for a period of at least 3 months.

REFERENCES

42 CFR 493.1241(c):
AABB Standard 5.11.1, 27th Edition,
The Interpretive Guidelines §482.23(c)2(i) and §482.23(c)3

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MACL Verbal Order Form BB.GEN.8.1

Patient Name:		
Medical Record Number		
Patient's DOB		
BBID(if Applicable):		
Surgical location/Rm #		
Ordering Physician: (First and Last Name)		
Name of person giving order		
Component (✔ if ordered)		Number of units
Red Cells		
Platelets		
Plasma		
Cyro		
Attributes: ( ) Irr ( ) CMV negative ( ) HgbS negative ( ) Other:_____		

History Checked by:_____

ABO/RH:_____ AG/AB:_____

Auto/DD units:_____ Comments:_____

Retype ABO/RH:_____

Place Sunquest Order labels Here:

Upon receipt of written orders attach to back of this form.

BB.GEN.2.0 Minimum Inventory

STATEMENT OF PURPOSE

To define the minimum levels of blood products to be available at all times.

SCOPE

This procedure applies to all Mid America Clinical Laboratory Blood Banks.
(Each site will have a specific minimum level.)

- **Community Hospital South**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	12	10	12	6		2			
RINF		1							LR,IRR,CMV- with ped bags attached. Fresh one delivered on Friday
Plasma	4		4				4		
Cryo	2 pools								
Platelets	1 apheresis available								

- **RL** = Red Cells Leukoreduced **RINF** = Red Cell Infant: <5days, Irr, LR, CMV neg
- Inventory is to be taken each shift. The Blood Bank associates are responsible for maintaining the minimum inventory and for calling the blood supplier for restock.
- When inventory falls below minimum levels, sufficient blood products should be ordered to maintain minimum inventory levels.
- Both the Indiana Blood Center and American Red Cross will network with other FDA approved blood centers to obtain blood products in the event of a local shortage.
- Blood products may be obtained from other Mid America Clinical Laboratories facilities in the case of a site-specific shortage.

BB.GEN.2.0 **Minimum Inventory**

STATEMENT OF PURPOSE

To define the minimum levels of blood products to be available at all times.

SCOPE

This procedure applies to all Mid America Clinical Laboratory Blood Banks.
(Each site will have a specific minimum level.)

MINIMUM INVENTORY PER SITE

- **St. Vincent - Indianapolis**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	100	40	100	20	15	6			
RINF	4	4	4						All CMV Negative & prestorage leukoreduced.
Plasma	20		30		10		20		
Cryo	4 pools		4 pools		4 pools		10 single cryo 4 pools		*Pools =pool of 5 units
Platelets	• 4 Platelet pheresis, any type for general population. • 2 A+/= platelet pheresis, for trauma • 1 AB +/= or A+/=, CMV negative, for neonatal use.								2 platelet phereis for general population to be CMV negative
Rh Immune Globulin	25 vials								

- **St. Vincent – Women's**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	10	8	10	6					
RINF		4							CMV Neg, LR, IRR
Plasma			8		2		4 adult 8 pedi		
Cryo			1 pool				5 single		
Platelets	1 A or AB								
Rh Immune Globulin	25 vials								

- St. Vincent - Jennings

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	8	4	6	2					

- St. Vincent Salem

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	8	4	8	4					
Rh Immune Globulin	2-5 vials								

- St. Vincent – Fishers (North East Medical Center)

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL		4*							2 CMV neg & Irr
Rh Immune Globulin									

- St. Vincent - Carmel

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	12	8	12	4		2	0	0	
RNF		1							
Plasma	4		4				6 - 1 AB infant		
Cryo	5		5						
Rh Immune Globulin	2 boxes of 10 vials each								

- St. Vincent - Mercy

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	6	10	7	4					
Plasma							6		
Rh Immune Globulin	4								

MACL Minimum Inventory

- **St. Vincent - Randolph**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	4	3	4	2	1	1			
Plasma							4		
Rh Immune Globulin	10								

- **IOH**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	5	6	6	4					
Plasma							6		

- **St. Vincent - Dunn**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	6	4*	6	4					• 2 CMV neg
Plasma							4		
Rh Immune Globulin									

- **St. Vincent - Anderson**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	22	6	22	6	5	2	2	2	
Plasma	6		6		6		6		
Rh Immune Globulin	10								

- **St. Vincent – St. Joseph Kokomo**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	10	4	10	4	2				
Plasma	6		6		4		4		
Rh Immune Globulin									

MACL Minimum Inventory

- **Community North**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	25	10	25	4					
RINF		1							<5 days, CMV=,LR,IRR pedi bags attached
Plasma	20		20		8		8 (at least one unit of ped plasma)		
Cryo			10 or 2 pools of 5				1 single or 1 pool		
Platelets	1 AB or A Rh neg or positive								CMV=,LR,IRR, pedi bags attached

- **The Indiana Heart Hospital**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	6	10	6	4					
Plasma	20		20		4		4		
Cryo	4		4		4				
Platelets	2*								

* 2 units of apheresis platelets will be kept on site Monday-Friday during normal surgical hours (6:30am-5pm). After normal hours, weekends and holidays a minimum of one unit will be kept on hand, if supply is available. Standing order of platelets is delivered on the following time table: Monday 2 units, Tuesday and Wednesday 3 units, Friday 1 unit. If patients are stable and the need is not emanate for the use of platelets, in order to conserve the product, the blood bank will not order additional units of platelets to arrive before the standing order.

- **Community Hospital East**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	20	10	20	10					
Plasma	10		10		10		10		
Cryo			2 pools						
Platelets	1 apheresis available								

- **Community Hospital South**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	12	10	12	6		2			
RINF		1							LR,IRR,CMV- with ped bags attached. Fresh one delivered on Friday
Plasma	4		4				4		
Cryo	2 pools								
Platelets	1 apheresis available								

MACL Minimum Inventory

- RL = Red Cells Leukoreduced RINF = Red Cell Infant: <5days, Irr, LR, CMV neg
- Inventory is to be taken each shift. The Blood Bank associates are responsible for maintaining the minimum inventory and for calling the blood supplier for restock.
- When inventory falls below minimum levels, sufficient blood products should be ordered to maintain minimum inventory levels.
- Both the Indiana Blood Center and American Red Cross will network with other FDA approved blood centers to obtain blood products in the event of a local shortage.
- Blood products may be obtained from other Mid America Clinical Laboratories facilities in the case of a site-specific shortage.

WRITTEN BY: Beth Hughes

IMPLEMENTATION DATE: Jan 2000

BB.Misc.4.0 Critical Blood Supply Policy

STATEMENT OF PURPOSE

To outline the steps to be taken Mid America Clinical Laboratories when there is a notification from the blood supplier of a "Critical Blood Shortage".

SCOPE

This document applies to all Mid America Clinical Laboratories Blood Banks.

POLICY

A. The site blood supplier notifies the Transfusion Service(s) (Medical Director, Blood Bank Supervisor or designee) that the blood supply is at a critically low level.

B. The supervisor/designee of each blood bank performs on immediate inventory of products on hand and communicates this to the Medical Director.

C. The Laboratory Medical Director contacts Transfusion Committee Chair(s) and together with the Blood Bank Supervisor(s) reviews immediate needs for blood products (crossmatch requests) needed for upcoming surgery. If a decision is made that current blood inventory may not meet anticipated need, elective surgical cases may need to be postponed or rescheduled. In this case the following people/departments are contacted:

1. Surgeons involved
2. Surgery Managers
3. Surgery Scheduling
4. Corporate communications officer
5. Chief of Medical Staff

Depending on the urgency and projected length of the blood shortage, consideration may be given to an urgent email notification of the entire Medical Staff.

D. Emergency requests for blood (intraoperative, ED, Labor and Delivery) should be immediately crossmatched and issued. If crossmatching is not possible due to the urgency of the request, follow policy for emergency release of blood.

E. With the resolution or easing of the blood shortage, the contacted individuals in section C shall be informed/updated.

4. REFERENCES

CHI Critical Blood Supply Policy
St. Vincent Hospitals and Health Services, Carmel and Indianapolis, Blood Shortage Notification Flow Sheet
St. Vincent Hospitals and Health Services Blood Shortage Memorandum

WRITTEN BY: Dr. Terry Cudahy and Dr. David Powers

IMPLEMENTATION DATE: April 2000

BB.GEN.7.0 RESOURCES - STAFFING

STATEMENT OF PURPOSE

This policy defines the determination of staffing levels within the blood banks and also defines the location and determination of job descriptions and qualifications.

SCOPE

This policy applies to all Mid America Clinical Laboratories blood banks

RELATED DOCUMENTS

MACL QUALITY PLAN

POLICY

A. Staffing requirements will be determined by the following criteria:
   1. Workload as determined by the IEB and workload recording programs in Sunquest.
   2. Overtime paid as determined by the payroll department.
   3. Staffing requirements for all shifts including weekends, holidays and vacations.
   4. The above criteria will be reviewed by the VP for Hospital Operations, HR and the site supervisor when staffing issues arise.

B. Role summaries are written and maintained in the Human Resources Department of Mid America Clinical Laboratories.
   1. Role Summaries are written by the Human Resources Department along with input from Directors and Supervisors.
   2. Job descriptions are maintained in the Human Resources Department residing at the Regional Facility on Shadeland Avenue.

C. Contingency Plans for staffing may include the following:
   1. Staff from other sites may be deployed to the area in need.
   2. Workload may be shifted to other sites (i.e. routine work may be sent to another location).
   3. Antibody identification and problem patients may be sent to the Reference Lab at Indiana Blood Center.

WRITTEN BY: Kim Coors, MT(ASCP)BB

IMPLEMENTATION DATE: Feb 2003

QA.GEN.1.5 MID AMERICA CLINICAL LABORATORIES SCOPE OF SERVICES

I. Mission

Our mission is to be the leading Indiana provider of quality clinical laboratory services achieved through the expertise, commitment, and creativity of our associates.

II. Scope of Services

Laboratory Testing Facilities

Mid America Clinical Laboratories includes a network of Hospital-Based Laboratories, Laboratory Service Centers, Point-of-Care Testing (POCT) services, and a Regional Reference Laboratory.

Hospital-Based Laboratories—The Hospital-Based Rapid Response Laboratories (RRL) perform stat and some routine testing 24 hours a day, 7 days a week, as necessary for appropriate patient care at each hospital location. Testing at these laboratories includes the following disciplines:

- Chemistry
- Coagulation
- Hematology
- Immunohematology (Blood Bank)
- Rapid and Routine Microbiology
- Urinalysis

Regional Reference Laboratory—The Regional Reference Laboratory performs routine and esoteric testing in the following clinical pathology disciplines:

- Chemistry
- Coagulation
- Gynecologic Cytology
- Hematology
- Immunohematology (Blood Bank)
- Immunology

- Microbiology (including Bacteriology, Mycology, Virology, Parasitology and Mycobacteriology)
- Molecular Diagnostics
- Urinalysis

Much of the testing at the Regional Reference Laboratory is performed overnight, to better support patient care by allowing at most 24-hour turnaround time for most routine, and some esoteric tests. Hours of service vary by department or testing area. This facility may be contacted through Customer Services.

Point-of-Care Testing—Point-of-Care Testing is performed and/or managed in many locations, including hospital patient care units, emergency departments, outpatient clinics, surgery centers and MACL Patient Care Centers (PCCs). MACL provides POCT oversight management or assistance to hospital clients to ensure all regulatory requirements are met. These services include: selection of POCT devices, training, review of data, performance of linearity/correlation studies, procedures, logs, investigation of new methods, proficiency testing selection and review, etc. A certified medical technologist and several POCT service representatives staff the department to support this program.

Laboratory Accreditation and Quality Assurance—MACL is accredited by the College of American Pathologists (CAP) and, for the St. Vincent Indianapolis Blood Bank, the American Association of Blood Banks (AABB). Both the CAP and the AABB are deemed accrediting agencies for the Centers for Medicare and Medicaid Services (CMS), the Federal agency that administers the Clinical Laboratory Improvement Amendments (CLIA), which is the set of Federal regulations covering clinical laboratory practices. Additionally, MACL services are monitored and approved by the Indiana State Department of Health (ISDH) and the Food and Drug Administration (FDA).

Board-certified pathologists direct all laboratory activities, providing medical and technical support services on a full-time basis. Well-trained and competent medical technologists, cytotechnologists, analytical scientists, medical laboratory technicians, and lab assistants enable MACL to provide precise and accurate test results. Day-to-day quality and accuracy are assured by internal quality control and external proficiency testing programs, as well as extensive competency assessment protocols. A comprehensive quality management program provides both guidance and monitoring of testing quality and service effectiveness.

Safety—MACL complies with all applicable safety and environmental requirements established by federal, state and local authorities (eg, OSHA, EPA, IDEM, ISDH).

Results Reporting Services—In accordance with regulations governing clinical laboratories and in order to maintain the confidentiality of personal health information, it is MACL policy to release test-related information only to the person who requested the test or to that person's representative.

Computer generated reports are charted in the hospitals or sent to physician offices or outside facilities by the best available means of communication: electronically, by courier, or by mail.

Reference ranges (normal ranges) with interpretation of results as indicated will be included on each patient test report. Because of continuing improvements in methodology and expanding knowledge in clinical interpretation, reference ranges do not remain static in a progressive laboratory. Each report will carry current reference ranges for the specific test.

Alert or critical results are flagged in the laboratory computer system when they exceed the verification range. All alert values are telephoned to the nursing unit or the physician. For those tests with established turnaround times, the laboratory will evaluate the urgency of the test result requested and notify the appropriate nursing unit or physician.

Turnaround times for STAT tests performed on site at the Hospital Based RRLs will be one hour or less from receipt in the laboratory. Turnaround times for routine tests performed by the Regional Reference Laboratory will be less than 16 hours. Most microbiology testing, esoteric testing, and gynecologic cytology will be available in 48 to 72 hours; dependent upon methodology. When appropriate, microbiology preliminary reports are often available after 24 hours.

Rapid Response Laboratory (RRL) Test Availability—Rapid Response Laboratory test menus vary slightly, dependent upon the needs of the facility's patient population and service mix. STAT orders for testing are targeted for result availability within 30 minutes for emergency department (ED) requests and 45 minutes for non-ED requests. The basic RRL test menu includes the tests shown in the table below. Again, this menu varies based on facility need due to patient population and service mix (eg, a facility offering transplant services may require the ability to monitor some transplant drug concentrations in their patients, another location may service patients who do not require some of the tests listed, such as gentamicin).

Rapid Response Laboratory (RRL) Sample Test Menu		
Acetaminophen	CPK	Occult Blood, Gastric
Acetone	Creatinine	Osmolality, Blood/Urine
Alanine Aminotransferase (ALT)	Crossmatch	Phosphorus
Albumin	D-Dimer	Platelet Count
Alcohol	Digoxin	Potassium, Serum/Plasma/Blood
Alkaline Phosphatase	Dilantin	Protein, Total, Blood
Ammonia	Direct Antiglobulin Test	Protein, Total, CSF
Amylase	Drug Screen, Urine (Triage)	Protime (PT, Prothrombin Time)
Antibody Screen	Electrolyte Panel, Blood	PTT (Partial Thromboplastin Time)
Antibody Screen, prenatal	Gentamicin	RBC Count
Aspartate Aminotransferase (AST)	Glucose, Blood	Renal Function Panel
Bacterial Vaginosis (BV)	Glucose, CSF	Respiratory Syncytial Virus (RSV)
Basic Metabolic Panel (BMET)	Glucose, Post Prandial, 2 hour	Rh Typing (includes weak D)
Bilirubin, Direct	Glucose Tolerance (various)	Salicylate
Bilirubin, Direct-Neonatal	Gram Stain	Sedimentation Rate
Bilirubin, Total	Group A Strep Screen	Sodium, Blood
Bilirubin, Total-Neonatal	HCG, Qualitative, Blood	Specific Gravity, Urine
Blood Type	HCG, Qualitative, Urine	Tegretol/Carbamazipine
BNP	HCG, Quantitative, Serum	Trichomonas Rapid Test (TRS)
BUN	Hematocrit	Trich Prep
Calcium	Hemoglobin	Troponin I
Calcium, Ionized	Hepatic Panel	Type and Crossmatch
Carbon Dioxide (CO2)	HIV 1/2 (Suds) Needlestick Protocol	Uric Acid, Blood
Carbon Monoxide (CO)	India Ink Prep	Urinalysis (UA)
CBC (no Differential)	Influenza A & B	Urinalysis Microscopic
CBC with Differential	Iron, Total	Urine, Ketone
Cell Count, Body Fluid	Lactic Acid, Blood	White Blood Cell Count
Cell Count, CSF	LDH	
Cell Count, Joint Fluid	Lipase	
Chloride	Magnesium	
CKMB	Mono Screen	
Clostridium difficile—Rapid	Myoglobin	
Comp. Metabolic Panel (CMET)	Occult Blood, Fecal	

Client Services

MACL recognizes that the laboratory's quality is defined by both technical and service quality. We will continually strive to understand, respond to, and meet the needs of our clients by functioning as their advocate; recognizing and responding to service opportunities and facilitating resolution.

The Client Services Department is available:

Monday – Friday	24 hours/day
Saturday	12:00 AM – 3:30 PM (RRLs take calls after 3:30 PM)
Sunday and Holidays	7:00 AM – 3:30 PM (Closed Christmas Day; RRLs take calls after 3:30 PM)

Client Services addresses all customer inquiries relative to specimen requirements, test results, test information, and duplicate reports or report retransmission, along with other questions and concerns.

Courier Services/Specimen Pick-up

Courier service is designed to meet the needs of our customers for specimen pick-up, and report and supply delivery to hospitals, clinics, physician offices, and nursing facilities throughout our service area.

Patient Care Centers

MACL has more than 20 Patient Care Center (PCCs) throughout Central Indiana. In addition to these locations, outpatient draw sites are located in many of our affiliated hospital locations. Hours for the hospital-based PCC locations are, at minimum, Monday-Friday 8 AM to 5 PM; some locations have Saturday hours. Information on specific locations is available through Client Services and the MACL webpage (www.maclonline.com) These PCCs are staffed with Phlebotomists who are required to complete competencies in age-specific training in phlebotomy and specimen preparation, including annual recertification in all areas. All associates undergo extensive compliance training, which includes coverage of HIPAA requirements.

Beyond these MACL-specific PCC locations, we have numerous in-office phlebotomists placed in clinics and physician practices throughout Central Indiana.

Community
Health Network

Community Hospital South
Emergency Department
1402 E. County Line Road
Indianapolis, Indiana 46227-0963
317-887-7200 (tel)
eCommunity.com

June 17, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner

Indiana State Trauma Care Committee

Indiana State Department of Health

2 North Meridian Street

Indianapolis, IN 46204

SUBJECT: Community Hospital South's Application for "in the ACS verification process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve in the role of Trauma Medical Director. I am pleased to support Community Hospital South's efforts to complete the "in the process" Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

Our trauma surgeons rotate call to be promptly available twenty-four hours per day. We are committed to responding to "Code Traumas" within thirty minutes of patient arrival. Surgeon response times are continuously evaluated by the Trauma Program Manager and through the hospital's Performance Improvement and Patient Safety program.

I am current with the ATLS certification requirement of the Trauma Medical Director.

Edward Diekhoff MD, FACS

Respectfully,

Edward Diekhoff, M.D., F.A.C.S.
Trauma Medical Director

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DK 05/30

June

General Surgical Care South On-call Schedule as of 5/21/2014

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 DIEKHOFF	2 CLARK	3 DIEKHOFF	4 BOWLDS	5 CLARK	6 O'NEIL	7 O'NEIL
8 O'NEIL	9 CLARK	10 O'NEIL	11 BOWLDS	12 O'NEIL	13 CLARK	14 CLARK
15 CLARK	16 DIEKHOFF	17 BOWLDS	18 CLARK	19 DIEKHOFF	20 BOWLDS	21 BOWLDS
22 BOWLDS	23 O'NEIL	24 DIEKHOFF	25 CLARK	26 BOWLDS	27 DIEKHOFF	28 DIEKHOFF
29 DIEKHOFF	30 O'NEIL					**Dr. O'Neil is unavailable 6/14/14 thru 6/22/14 & 6/26/14 thru 6/29/14**

2014

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Community 5/30/2014 10:38:50 AM PAGE 2/002 Fax Server

May

General Surgical Care South On-call Schedule

Sun	*Mon*	*Tue*	*Wed*	*Thu*	*Fri*	*Sat*
Dr. Diekhoff is unavailable 4/17/14 thru 5/04/14 & 5/17/14 thru 5/18/14	**Dr. Clark is unavailable 5/02/14 thru 5/08/14**	**Dr. Bowlds is unavailable 5/03/14 thru 5/04/14 & 5/17/14 thru 5/18/14**	**Dr. O'Neil is unavailable 5/10/14 thru 5/11/14**	1 CLARK	2 O'NEIL	3 O'NEIL
4 O'NEIL	5 BOWLDS	6 O'NEIL	7 BOWLDS	8 O'NEIL	9 BOWLDS	10 BOWLDS
11 BOWLDS	12 CLARK	13 O'NEIL	14 CLARK	15 BOWLDS	16 O'NEIL	17 O'NEIL
18 O'NEIL	19 CLARK	20 DIEKHOFF	21 BOWLDS	22 DIEKHOFF	23 CLARK	24 CLARK
25 CLARK	26 CLARK Memorial Day	27 DIEKHOFF	28 BOWLDS	29 CLARK	30 DIEKHOFF	31 DIEKHOFF

2014

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Community 6/17/2014 8:58:10 AM PAGE 2/002 Fax Server

April

General Surgical Care South On-call Schedule as of 04/28/13

Sun	*Mon*	*Tue*	*Wed*	*Thu*	*Fri*	*Sat*
Dr. O'Neil is unavailable 3/28/14 thru 4/6/14	**Dr. Bowlds is unavailable 3/31/14 thru 4/6/14**	1 CLARK	2 DIEKHOFF	3 CLARK	4 DIEKHOFF	5 DIEKHOFF
6 DIEKHOFF	7 CLARK	8 DIEKHOFF	9 BOWLDS	10 O'NEIL	11 BOWLDS	12 BOWLDS
13 BOWLDS	14 DIEKHOFF	15 O'NEIL	16 DIEKHOFF	17 CLARK	18 O'NEIL	19 O'NEIL
20 O'NEIL	21 BOWLDS	22 O'NEIL	23 BOWLDS	24 O'NEIL	25 CLARK	26 CLARK
27 CLARK	28 O'NEIL	29 BOWLDS	30 **BOWLDS**	**Dr. Diekhoff is unavailable 4/17/14 thru 5/04/14**	**Dr. Clark is unavailable 4/11/14 & 4/23/14**	

2014

Jun. 17. 2014 1:33PM Community Physician Network No. 8200 P. 1/1

Trauma Surgeon response Log for "Code Trauma's "

CHS 2014

Date	*Patient MRN*	*Time of patient arrival*	*Time of Trauma Surgeon arrival*	*Total Minutes to response*	*Trauma Surgeon*
01/01/2014	00012564	0323	0340	17min.	Diekhoff

315

Community
Health Network

Community Hospital South
Emergency Department
1402 E. County Line Road
Indianapolis, Indiana 46227-0963
317-887-7200 (tel)
eCommunity.com

June 16, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner

Indiana State Trauma Care Committee

Indiana State Department of Health

2 North Meridian Street

Indianapolis, IN 46204

SUBJECT: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center Designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that Dr. Diekhoff, our Trauma Medical Director, is a member of the Community Hospital South Emergency Management Committee.

Respectfully,

Elisa Stott

Elisa Stott
Network Emergency Preparedness
Coordinator and Safety Manager

Edward Diekhoff MD, FACS

Edward Diekhoff, M.D., F.A.C.S
Trauma Medical Director

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 7

Emergency Department Physician Coverage

7. "**In-house Emergency Department physician coverage.** The Emergency Department must have a designated emergency physician director, supported by an appropriate number of additional physicians to ensure immediate care for injured patients."

Narrative Response and Discussion

The requirements of section 7 are met with a signed letter from Dr. Joel Parker. Dr. Parker is the Chief Medical Director for Indiana Emergency Solutions at Community Hospital South. The letter affirms that there is twenty – four hour in-house coverage of emergency physicians to care for injured patietns.

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June 16, 2014

William C. VanNess II, M.D., - Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

Indiana Emergency Solutions a division of EmCare provides physician coverage to the Emergency Department at Community Hospital South. IES currently has 18 physicians credentialed on staff at Community Hospital South who ensure the immediate care of all sick and injured patients in our emergency department. All physicians on staff are board certified or board eligible in a specialty recognized by the American Board of Medical Specialties.

I am the Chief Medical Director for the Emergency Department at Community Hospital South. As the Director, I ensure that the standards of quality and efficiency are maintained by the ED physicians on a daily basis.

Respectfully,

Joel Parker, M.D.
Chief Medical Director
Indiana Emergency Solutions

319

Community Hospital South - ED
1402 E. County Line Road
Indianapolis, IN 46227

Released: 02/03/14 5:39 pm
Revised: 02/04/14 9:46 am

YSICIAN: MARCH 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1 D - A SANDERS M - TAKESUE E - BENCE N - WOODALL
2 D - E PARKER M - TAKESUE E - BENCE N - WOODALL	3 D - BENEDICT M - E PARKER E - DWYER N - BENCE	4 D - J PARKER M - A SANDERS E - WOODALL N - KOPCZYNSKI	5 D - J PARKER M - A SANDERS E - DWYER N - KOPCZYNSKI	6 D - B. BLACK M - BENEDICT E - BENCE N - KOPCZYNSKI	7 D - E PARKER M - J PARKER E - HELMS N - KOPCZYNSKI	8 D - MURPHY M - TAKESUE E - MOZES N - HELMS
9 D - BENEDICT M - STUCKWISCH E - MOZES N - KOPCZYNSKI	10 D - BENCE M - BENEDICT E - DWYER N - KOPCZYNSKI	11 D - HELMS M - MOZES E - WOODALL N - DWYER	12 D - HELMS M - A SANDERS E - WOODALL N - E PARKER	13 D - B. BLACK M - A SANDERS E - BENCE N - KOPCZYNSKI	14 D - WOODALL M - E PARKER E - BENCE N - KOPCZYNSKI	15 D - WOODALL M - TAKESUE E - BENCE N - KOPCZYNSKI
D - WOODALL M - TAKESUE E - DWYER N - KOPCZYNSKI	17 D - WOODALL M - MOZES E - E PARKER N - DWYER	18 D - BENEDICT M - E PARKER E - HELMS N - DWYER	19 D - BENCE M - J PARKER E - E PARKER N - HELMS	20 D - WOODALL M - MOZES E - DWYER N - HELMS	21 D - BENCE M - A SANDERS E - DWYER N - KOPCZYNSKI	22 D - J PARKER M - BENCE E - HELMS N - KOPCZYNSKI
23 D - DWYER M - BENCE E - HELMS N - KOPCZYNSKI	24 D - DWYER M - HELMS E - WOODALL N - KOPCZYNSKI	25 D - E PARKER M - MOZES E - WOODALL N - KOPCZYNSKI	26 D - J PARKER M - HELMS E - DWYER N - KOPCZYNSKI	27 D - B. BLACK M - HELMS E - E PARKER N - BENCE	28 D - MOZES M - WOODALL E - E PARKER N - BENCE	29 D - HELMS M - STUCKWISCH E - E PARKER N - KOPCZYNSKI
30 D - J PARKER M - STUCKWISCH E - DWYER N - WOODALL	31 D - J PARKER M - BENCE E - BENEDICT N - WOODALL					

Day: 6AM-2PM
MID: 11AM-9PM
Eve: 2PM-12AM
Night: 9PM-6AM

For any scheduling changes, please contact:
Nick Ragsdale

Scheduler - Nick Ragsdale Ragsdale

Recruiter - John Magombo

* = Pending Privileges

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320

Community Hospital South - ED
1402 E. County Line Road
Indianapolis, IN 46227-

Released: 03/04/14 9:47-am

Revised: 03/04/14 9:47 am

IYSICIAN: APRIL 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1 D - * EPPLER M - BENCE E - MOZES N - KOPCZYNSKI	2 D - * EPPLER M - BENCE E - WOODALL N - KOPCZYNSKI	3 D - * EPPLER M - WOODALL E - BENEDICT N - KOPCZYNSKI	4 D - E PARKER M - J PARKER E - BENCE N - KOPCZYNSKI	5 D - HELMS M - A SANDERS E - STUCKWISCH N - E PARKER
6 D - HELMS M - DWYER E - STUCKWISCH N - BENCE	7 D - WOODALL M - A SANDERS E - HELMS N - BENCE	8 D - J PARKER M - E PARKER E - A SANDERS N - DWYER	9 D - WOODALL M - E PARKER E - BENCE N - HELMS	10 D - WOODALL M - A SANDERS E - DWYER N - HELMS	11 D - WOODALL M - BENEDICT E - DWYER N - KOPCZYNSKI	12 D - J PARKER M - E PARKER E - TAKESUE N - DWYER
13 D - * EPPLER M - STUCKWISCH E - TAKESUE N - WOODALL	14 D - MOZES M - A SANDERS E - DWYER N - E PARKER	15 D - BENEDICT M - A SANDERS E - DWYER N - WOODALL	16 D - HELMS M - J PARKER E - E PARKER N - KOPCZYNSKI	17 D - DWYER M - BENCE E - WOODALL N - KOPCZYNSKI	18 D - HELMS M - BENCE E - BENEDICT N - KOPCZYNSKI	19 D - A SANDERS M - WOODALL E - B. BLACK N - KOPCZYNSKI
20 D - TAKESUE M - MOZES E - B. BLACK N - KOPCZYNSKI	21 D - BENEDICT M - J PARKER E - E PARKER N - KOPCZYNSKI	22 D - B. BLACK M - DWYER E - HELMS N - KOPCZYNSKI	23 D - WOODALL M - HELMS E - E PARKER N - MOZES	24 D - DWYER M - WOODALL E - E PARKER N - HELMS	25 D - DWYER M - E PARKER E - MOZES N - WOODALL	26 D - BENCE M - DWYER E - TAKESUE N - KOPCZYNSKI
27 D - BENCE M - STUCKWISCH E - TAKESUE N - KOPCZYNSKI	28 D - E PARKER M - WOODALL E - BENCE N - DWYER	29 D - E PARKER M - J PARKER E - A SANDERS N - BENCE	30 D - MOZES M - A SANDERS E - DWYER N - HELMS			

Day: 6AM-2PM
MID: 11AM-9PM
Eve: 2PM-12AM
Night: 9PM-6AM

For any scheduling changes, please contact:
Nick Ragsdale

Scheduler - Nick Ragsdale Ragsdale

Recruiter - John Magombo

*** = Pending Privileges**

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Community Hospital South - ED
1402 E. County Line Road
Indianapolis, IN 46227-

Released: 04/04/14 9:18 am

YSICIAN: MAY 2014

Revised: 04/15/14 3:10 pm

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1 D - MOZES M - DWYER E - WOODALL N - HELMS	2 D - BENCE M - J PARKER E - E PARKER N - WOODALL	3 D - A SANDERS M - J PARKER E - E PARKER N - BENCE
4 D - DWYER M - J PARKER E - MOZES N - BENCE	5 D - BENEDICT M - E PARKER E - HELMS N - DWYER	6 D - WOODALL M - J PARKER E - HELMS N - DWYER	7 D - STUCKWISCH M - J PARKER E - E PARKER N - KOPCZYNSKI	8 D - A SANDERS M - HELMS E - BENEDICT N - KOPCZYNSKI	9 D - MOZES M - A SANDERS E - E PARKER N - KOPCZYNSKI	10 D - WOODALL M - MOZES E - TAKESUE N - KOPCZYNSKI
11 D - BENCE M - WOODALL E - TAKESUE N - KOPCZYNSKI	12 D - DWYER M - BENEDICT E - BENCE N - E PARKER	13 D - HELMS M - WOODALL E - A SANDERS N - KOPCZYNSKI	14 D - HELMS M - WOODALL E - DWYER N - KOPCZYNSKI	15 D - MULVEY M - A SANDERS E - BENCE N - KOPCZYNSKI	16 D - STUCKWISCH M - HELMS E - DWYER N - BENCE	17 D - * EPPLER M - HELMS E - BENEDICT N - MOZES
-6 D - * EPPLER M - HELMS E - TAKESUE N - KOPCZYNSKI	19 D - J PARKER M - E PARKER E - DWYER N - KOPCZYNSKI	20 D - BENCE M - BENEDICT E - A SANDERS N - KOPCZYNSKI	21 D - E PARKER M - J PARKER E - A SANDERS N - HELMS	22 D - MOZES M - DWYER E - * * * OPEN * * * N - HELMS	23 D - E PARKER M - DWYER E - BENCE N - MOZES	24 D - B. BLACK M - DWYER E - TAKESUE N - E PARKER
25 D - J PARKER M - DWYER E - TAKESUE N - KOPCZYNSKI	26 D - A SANDERS 6:00A-6:00P M - STUCKWISCH 11:00A-11:00P N - KOPCZYNSKI 6:00P-6:00A	27 D - BENEDICT M - J PARKER E - DWYER N - MOZES	28 D - E PARKER M - HELMS E - B. BLACK N - KOPCZYNSKI	29 D - * EPPLER M - BENCE E - B. BLACK N - DWYER	30 D - J PARKER M - BENCE E - HELMS N - KOPCZYNSKI	31 D - J PARKER M - STUCKWISCH E - E PARKER N - KOPCZYNSKI

Day: 6AM-2PM
MID: 11AM-9PM
Eve: 2PM-11PM
Night: 9PM-6AM

For any scheduling changes, please contact:
Nick Ragsdale

Scheduler - Nick Ragsdale Ragsdale

Recruiter - John Magombo

* = Pending Privileges

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Community Hospital South - ED
1402 E. County Line Road
Indianapolis, IN 46227-

Released: 05/05/14 3:41 pm

IYSICIAN: JUNE 2014

Revised: 05/06/14 10:48 am

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 D - J PARKER M - STUCKWISCH E - B. BLACK N - DWYER	2 D - BENEDICT M - COY E - MOZES N - DWYER	3 D - J PARKER M - COY E - BENEDICT N - KOPCZYNSKI	4 D - HELMS M - COY E - J PARKER N - KOPCZYNSKI	5 D - HELMS M - BENEDICT E - COY N - BENCE	6 D - HELMS M - J PARKER E - MOZES N - BENCE	7 D - A SANDERS M - TAKESUE E - HELMS N - MOZES
8 D - J PARKER M - TAKESUE E - BENEDICT N - MOZES	9 D - DWYER M - A SANDERS E - BENCE N - HELMS	10 D - J PARKER M - DWYER E - A SANDERS N - KOPCZYNSKI	11 D - MOZES M - DWYER E - A SANDERS N - KOPCZYNSKI	12 D - BENCE M - DWYER E - HELMS N - KOPCZYNSKI	13 D - J PARKER M - BENEDICT E - MOZES N - HELMS	14 D - J PARKER M - STUCKWISCH E - BENCE N - MOZES
15 D - DWYER M - STUCKWISCH E - BARKER N - KOPCZYNSKI	16 D - J PARKER M - DWYER E - BARKER N - KOPCZYNSKI	17 D - J PARKER M - BENEDICT E - BENCE N - KOPCZYNSKI	18 D - A SANDERS M - J PARKER E - BENCE N - KOPCZYNSKI	19 D - COY M - A SANDERS E - DWYER N - IRWIN II	20 D - BENCE M - A SANDERS E - DWYER N - IRWIN II	21 D - BENCE M - TAKESUE E - DWYER N - KOPCZYNSKI
D - BENCE M - TAKESUE E - DWYER N - KOPCZYNSKI	23 D - A SANDERS M - HELMS E - J PARKER N - KOPCZYNSKI	24 D - EPPLER M - HELMS E - B. BLACK N - DWYER	25 D - EPPLER M - BENEDICT E - HELMS N - DWYER	26 D - BENCE M - BARKER E - HELMS N - DWYER	27 D - J PARKER M - A SANDERS E - BENCE N - KOPCZYNSKI	28 D - J PARKER M - STUCKWISCH E - HELMS N - KOPCZYNSKI
29 D - J PARKER M - STUCKWISCH E - HELMS N - KOPCZYNSKI	30 D - DWYER M - BENCE E - HELMS N - KOPCZYNSKI					
		Day: 6AM-2PM **MID: 11AM-9PM** **Eve: 2PM-11PM** **Night: 9PM-6AM**				

For any scheduling changes, please contact:
Nick Ragsdale

Scheduler - Nick Ragsdale Ragsdale

Recruiter - John Magombo

*** = Pending Privileges**

For after regular business hours emergenices, contact Answering Service a

DO NOT CALL NICK DIRECTLY.

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Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 8

Orthopedic Surgery

8. "**Orthopedic Surgery.** There must be an orthopedic surgeon on call and promptly available 24 hours per day. There must also be a written letter of commitment, signed by orthopedic surgeons and the Trauma Medical Director, for this requirement."

Narrative Response and Discussion

The requirements of section 8 are met with a signed letter of commitment from Dr. Kevin Julian, M.D., Orthopedic Surgeon liaison to the Community Hospital South PIPS committee. This letter affirms that Community Hospital South has orthopedic surgeons promptly available twenty – four hours per day.

Community
Health Network

Community Hospital South
Emergency Department
1402 E. County Line Road
Indianapolis, Indiana 46227-0963
317-887-7200 (tel)
eCommunity.com

June 16, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I am the orthopedic surgery liaison to the Trauma Performance Improvement and Patient Safety (PIPS) committee. I am pleased to support Community Hospital South's effort to complete the "in the process" Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

Two orthopedic groups, Greenwood Orthopedics, Ortho Indy, and Dr. MacInstosh provide orthopedic surgeon on – call to Community Hospital South. An orthopedic surgeon is promptly available 24 hours per day. The surgeon on call is provided to the Emergency Department staff one month in advance with any changes being communicated via email.

Respectfully,

Kevin Julian, M.D.
Orthopedic Surgery
Chief of Medical Staff

Edward Diekhoff MD FACS

Edward Diekhoff, M.D., F.A.C.S.
Trauma Medical Director

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Cor unity Hospital South Call Schedule for ril 2014

April 2014

April 2014

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

May 2014

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Mar 30 - Apr 5	**Mar 30**	**31**	**Apr 1** OI Lavery	**2** Jackson	**3** OI Lavery	**4** OI Justice	**5** OI Dilella
Apr 6 - 12	**6** OI Dilella	**7** McIntosh	**8** OI Justice	**9** Jackson	**10** Martin	**11** Julian	**12** Julian
Apr 13 - 19	**13** Julian	**14** Martin	**15** Jackson	**16** Julian	**17** OI Justice	**18** McIntosh	**19** McIntosh
Apr 20 - 26	**20** McIntosh	**21** OI Justice	**22** Martin	**23** OI Lavery	**24** OI Justice	**25** OI Falender	**26** OI Falender
Apr 27 - May 3	**27** OI Falender	**28** Jackson	**29** OI Lavery	**30** Martin	**May 1**	**2**	**3**

Community Hospital South Call Schedule for May 2014

May 2014

May 2014

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June 2014

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Apr 27 - May 3	Apr 27	28	29	30	May 1 McIntosh	2 O.I. Falender	3 O.I. Falender
May 4 - 10	4 O.I. Lavery	5 McIntosh	6 Martin	7 Jackson	8 O.I. Lavery	9 Julian	10 Julian
May 11 - 17	11 Julian	12 O.I. Justice	13 Julian	14 McIntosh	15 O.I. Lavery	16 Jackson	17 Jackson
May 18 - 24	18 Jackson	19 O.I. Woo	20 O.I. Dilella	21 McIntosh	22 O.I. Falender	23 Martin	24 Martin
May 25 - 31	25 Martin	26 O.I. Dilella	27 O.I. Justice	28 O.I. Dilella	29 O.I. Justice	30 O.I. Lavery	31 O.I. Lavery

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Community Hospital South Call Schedule for June 2014 DRY 05/30

June 2014

June 2014

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

July 2014

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Jun 1 - 7	Jun 1 O.I. Lavery	2 Julian	3 Martin	4 Martin	5 Julian	6 McIntosh	7 McIntosh
Jun 8 - 14	8 McIntosh	9 Martin	10 Jackson	11 Martin	12 O.I. Falender	13 O.I. Justice	14 O.I. Justice
Jun 15 - 21	15 O.I. Justice	16 Jackson	17 O.I. Lavery	18 Jackson	19 McIntosh	20 O.I. Dilella	21 O.I. Dilella
Jun 22 - 28	22 O.I. Falender	23 Julian	24 Jackson	25 O.I. Lavery	26 Julian	27 O.I. Justice	28 O.I. Justice
Jun 29 - Jul 5	29 O.I. Justice	30 O.I. Dilella	Jul 1	2	3	4	5

Martha Carpenter

5/12/2014 7:53 AM

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 9

Neurosurgery

9. "**Neurosurgery.** The hospital must have a plan that determines which type of neurologic injuries should remain at the facility for treatment and which types of injuries should be transferred out for a higher level of care. This plan must be agreed upon by the neurosurgical surgeon and the facility's Trauma Medical Director. There must be a transfer agreement in place with Level I or Level II trauma centers for the hospital's neurosurgical patient population. The documentation must include a signed letter of commitment by neurosurgeons and the Trauma Medical Director."

Narrative Response and Discussion

The requirements of section 9 are met with a signed letter of commitment and a neurosurgery plan for trauma patients from Community Health Network's Chief of Neurosurgery the Trauma Medical Director of Community Hospital South. There is a transfer agreement in place with Eskenazi Health and IU Health for adult neurosurgery patients. Community Health Network Neurosurgeons provide coverage twenty-four hours per day.

Community
Health Network

June 16, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve as the Chief of Neurosurgery for Community Health Network. I am pleased to support Community Health Network's effort to complete the "in the process" Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

The Neurosurgeons at Community Health Network are committed to providing care for patients with traumatic injury. I further understand that we have transfer agreements in place to accept trauma patient transfers determined to be beyond our scope by our Neurosurgery plan for trauma patients.

Respectfully,

John T. Cummings Jr., M.D.
Chief of Neurosurgery

Edward Diekhoff, M.D., F.A.C.S.
Trauma Medical Director

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Community
Health Network

Neurosurgery Plan for Trauma Patients

The following list of injuries with known or suspected neurological involvement will be considered for rapid transfer to a Level I trauma center if a Community Health Network Neurosurgeon and appropriate resources are not available.

- Penetrating injury/open fracture with or without cerebrospinal fluid leak
- Intra-cranial hemorrhage
- Depressed skull fracture
- GCS <11 or deteriorating mental status or lateralizing neurological signs
- Spinal cord injury or major vertebral injury
- Carotid or vertebral arterial injury

Respectfully,

John T. Cummings, Jr. M.D.
Chief of Neurosurgeon

Edward Diekhoff, M.D., F.A.C.S.
Trauma Medical Director

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CHE / CHN NEUROSURGEON ON CALL 4pm-7 am

April 2014

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	31	1 Hall	2 Donaldson	3 Kim	4 Rendel	5 Rendel 24 Hr Coverage
6 Rendel 24 Hr Coverage	7 Sloan	8 Cummings	9 Rendel	10 Sloan	11 Donaldson	12 Donaldson 24 Hr Coverage
13 Donaldson 24 Hr Coverage	14 Hall	15 Sloan	16 Cummings	17 Rendel	18 Kim	19 Kim 24 Hr Coverage
20 Kim 24 Hr Coverage	21 Hall	22 Donaldson	23 Hall	24 Sloan	25 Cummings	26 Cummings 24 Hr Coverage
27 Cummings 24 Hr Coverage	28 Sloan	29 Kim	30 Hall			

Dr. Cummings - Pager
Dr. Sloan - Pager
Dr. Donaldson - Pager
Dr Hall - Pager
Dr. Rendel - Pager
Dr. Kim - Pager

NIGHT CALL

**Weekends and Holidays are 24 hour coverage unless noted.

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CHE / CHN NEUROSURGEON ON CALL 4pm - 7am

May 2014

Please call [illegible] uring office hours

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
				1 Rendel	2 Kim	3 Kim 24 Hour Coverage
4 Kim 24 Hour Coverage	5 Donaldson	6 Hall	7 Donaldson	8 Cummings	9 Hall Dr. Donaldson PTO	10 Hall 24 Hour Coverage
11 Hall 24 Hour Coverage	12 Sloan	13 Donaldson	14 Sloan	15 Cummings DCH & RBS Mtg.	16 Rendel DCH & RBS Mtg.	17 Rendel 24 Hour Coverage
18 Rendel 24 Hour Coverage	19 Hall	20 Cummings	21 Donaldson	22 Kim	23 Sloan JTC & JWD PTO	24 Sloan 24 Hour Coverage
25 Sloan 24 Hour Coverage	26 Rendel Memorial Day 24 Hour Coverage	27 Sloan	28 Donaldson	29 Kim	30 Cummings	31 Cummings 24 Hour Coverage

Dr. Cummings - Pager
Dr. Sloan -
Dr. Donaldson -
Dr Hall - Pager
Dr. Rendel - Pager
Dr. Kim - Page

**Weekends & Holidays are 24 hour coverage

NIGHT CALL

9:33

JUN/17/2014/TUE 09:00 AM Community Neuro CHS FAX No. 317 497-2508 P. 001

CHE / CHN/CHS NEUROSURGEON ON CALL 4pm-7 am

June 2014

TLK 6/10

Please call the office at during regular office hours

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					30 Cummings	31 Cummings 24 Hour Coverage
1 Cummings 24 Hour Coverage	2 Donaldson	3 Rendel	4 Sloan	5 Cummings	6 Kim	7 Kim 24 Hour Coverage
8 Kim 24 Hour Coverage	9 Hall	10 Sloan	11 Cummings	12 Rendel	13 Sloan	14 Sloan 24 Hour Coverage
15 Sloan 24 Hour Coverage	16 Hall	17 Cummings	18 Kim	19 Hall	20 Rendel	21 Rendel 24 Hour Coverage
22 Rendel 24 Hour Coverage	23 Donaldson	24 Cummings	25 Sloan	26 Kim	27 Donaldson	28 Donaldson 24 Hour Coverage
29 Donaldson	30 Sloan					

Dr. Cummings - Pager
Dr. Sloan - Pager
Dr. Donaldson - Pager
Dr Hall - Pager
Dr. Rendel - Pager
Dr. Kim - Pager

**Weekend and Holiday Call is 24 Hour Coverage

NIGHT CALL

9223

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 10

Transfer Criteria And Agreements

10. "**Transfer agreements and criteria.** The hospital must include as a part of its application a copy of its transfer criteria and copies of its transfer agreements with other hospitals."

Narrative Response and Discussion

The requirements of section 10 are met with a copy of the Community Health Network Trauma Transfer Guidelines and trauma transfer agreements with adult and pediatric Level I trauma centers.

Community Health Network has established a relationship with Eskenazi Health as our trauma mentor hospital. In addition to opportunities for education and performance improvement there is a signed transfer agreement that covers adult trauma patients including neurological and burn care.

Also enclosed is a signed transfer agreement with IU Health. This agreement covers the transfer of adult and pediatric patients. Riley provides neurosurgical and burn care to pediatric patients.

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Community
Health Network

Trauma Transfer Guidelines

- The on call Trauma Surgeon or Emergency Department physician will decide which patients are to be transferred to a higher level of care.
- The injuries listed below are strongly recommended by the American College of Surgeons to be transferred to a level I or level II designated center.
  - ✓ Carotid or vertebral arterial injury
  - ✓ Torn thoracic aorta or great vessel
  - ✓ Cardiac rupture
  - ✓ Bilateral pulmonary contusion with PaO2 to FiO2 ratio less than 200
  - ✓ Major abdominal vascular injury
  - ✓ Grade IV or V liver injuries requiring >6 U RBC transfusion in 6 hours
  - ✓ Unstable pelvic fracture requiring > 6 U RBC transfusion in 6 hours
  - ✓ Fracture or dislocation with loss of distal pulses
  - ✓ Penetrating injury or open fracture of the skull
  - ✓ Glassgow Coma Scale < 14 or lateralizing neurologic signs
  - ✓ > 2 unilateral rib fractures or bilateral rib fractures with pulmonary contusion
  - ✓ Open long bone fracture
  - ✓ Significant torso injury with advanced comorbid disease
- The on call trauma Surgeon or Emergency Department physician will call for all patients being transferred to Eskenazi and will be connected directly to Eskenazi's on call trauma surgeon.
- For patients being transferred to IU Health the Surgeon or Emergency Department physician will call the IU Health 24/7 Transfer Center at
- The Surgeon or Emergency Department physician will decide if the patient travels via ground or aeromedical transportation with the most appropriate level of care (ALS, BLS).
- There will not be any delay in transfer due to laboratory or diagnostic testing that does not have any impact on the resuscitation of the patient.
- The transferring RN will complete the transfer checklist.
- The transferring RN will call report to the receiving facility.
- The transferring RN will complete the transfer form (electronic and paper).
- The transferring RN will accompany the patient when deemed necessary by the Surgeon or Emergency Department physician.

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TITLE: EMTALA: EMERGENCY MEDICAL SCREENING, STABILIZATION AND TRANSFER

Background and Purpose: This policy outlines the responsibilities of the Community Health Network hospitals (Hospitals) under the **E**mergency **M**edical **T**reatment and **L**abor **A**ct (EMTALA). EMTALA was enacted in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, primarily in response to concern that some emergency departments across the country had refused to treat indigent and uninsured patients or had inappropriately transferred them to other hospitals, a practice known as "patient dumping." EMTALA requires hospitals that participate in Medicare to provide a medical screening examination to any person who comes to the emergency department, regardless of the individual's ability to pay. If a hospital determines that the person has an emergency medical condition, it must provide treatment to stabilize the condition or provide for an appropriate transfer to another facility. Along with these primary responsibilities, EMTALA also places additional, related responsibilities on participating hospitals.

Policy:

1. Definitions. The following words or terms used in this policy have the definitions given below:
    a. "Capacity" means the ability of the Hospital to accommodate the individual requesting examination or treatment of the transferred individual. "Capacity" includes such things as numbers and availability of qualified staff, beds and equipment, and the Hospital's past practices of accommodating additional patients in excess of its occupancy limits.
    b. "Comes to the emergency department" means the individual:
        i. Has presented at the Hospital's emergency department (ED) and requests examination or treatment for a medical condition, or has such a request made on his or her behalf. A "request" for examination or treatment under this policy will be considered to have occurred if, based upon the individual's appearance or behavior, a prudent layperson observer would believe that the individual needs examination or treatment for a medical condition;
        ii. Has presented on Hospital property (other than the ED) and requests examination or treatment for what may be an emergency medical condition;
        iii. Is in a ground or air ambulance owned and operated by the Hospital, even if the ambulance is not on Hospital property, unless (1) the ambulance is operated under community-wide EMS protocols that direct it to transport the individual to another hospital; or (2) the ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the Hospital;
        iv. Is in a ground or air ambulance NOT owned by the Hospital, but is on Hospital property for examination and treatment for a medical condition at the Hospital's ED. This is true even if Hospital personnel correctly informed EMS personnel of the Hospital being on official diversionary status and the EMS personnel disregarded that information and brought the individual onto Hospital property anyway[1].
    c. "Dedicated emergency department" (DED) means any department or facility of the Hospital, whether on or off the main campus of the Hospital, that
        i. Is licensed by the State as an emergency department;

[1] If the Hospital is officially on diversionary status and EMS personnel contact the Hospital by radio or phone to transport an individual, Hospital personnel may direct the ambulance to another facility. However, if the ambulance comes to the Hospital anyway, the Hospital now has an EMTALA obligation to the individual being transported.

ii. Holds itself out to the public as a place that provides care for emergency medical conditions on an urgent basis without requiring an appointment (this includes the Network's Family Rooms, Behavioral Health Pavilion, and MedChecks); or
iii. Has provided at least one-third of its outpatient services in the last calendar year on an urgent basis without requiring prior appointments.

d. "Emergency Medical Condition" or (EMC) means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms or substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
   i. Placing the health of the individual (or with respect to a pregnant woman, placing the health of the woman or the unborn child) in serious jeopardy;
   ii. Serious impairment to bodily functions; or
   iii. Serious dysfunction of any bodily organ or part.

   With respect to a pregnant woman who is having contractions:
   i. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
   ii. That transfer may pose a threat to the health or safety of the woman or the unborn child.

e. "Hospital property" means the entire main Hospital campus (defined as the physical area immediately adjacent to the main hospital buildings and other hospital areas and structures that are within 250 yards of the main buildings), including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the Hospital's main building that are not part of the Hospital, such as physician offices or non-medical facilities.

f. "Labor" means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta.

g. "Stabilize" means, with respect to an emergency medical condition, to provide medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to occur during the transfer of the individual from a facility or that the woman has delivered the child and the placenta.

h. "Transfer" means the movement (including the discharge) of an individual outside the Hospital's facilities at the direction of any person employed by, affiliated or associated, directly or indirectly, with the Hospital.

2. Hospital Responsibilities Under EMTALA. All hospitals with a dedicated emergency department, must provide an appropriate medical screening examination for any individual who comes to the emergency department to determine whether an emergency medical condition exists. If an emergency medical condition is determined to exist, the Hospital must provide any necessary stabilizing treatment and/or an appropriate transfer.

   The Hospital's EMTALA obligation is also triggered if an individual comes elsewhere on Hospital property (that is, other than the ED) and either requests examination and treatment for an EMC or appears to be, from the perspective of a prudent layperson, suffering from an EMC. For all areas outside of the ED on Hospital property, if a health care professional or other individual is not available or unable to escort/transport the individual to the ED, 911 should be called. 911 responders can provide treatment and/or transfer the individual to the ED. Exception: For an individual experiencing cardiopulmonary arrest within the hospital or

certain other designated areas as set forth in the Cardiopulmonary Resuscitation Policy (CLN #2005), the Code Blue Team should be summoned.

EMTALA does NOT apply to Hospital inpatients or to registered outpatients who have begun to receive a scheduled course of outpatient care. However, other policies of CHNw and laws and regulations apply to inpatients and registered outpatients that must be followed.

a. Medical Screening Examination. The Hospital must provide an appropriate medical screening examination (MSE). An "appropriate MSE" is
   i. An exam that is performed within the capability of the Hospital's emergency department, including any ancillary services routinely available to the ED (i.e., x-ray, lab services, etc.), to determine if an emergency medical condition exists or not;
   ii. The ongoing process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist;
   iii. Reflected in the medical record with continued monitoring according to the patient's needs until he/she is stabilized or appropriately transferred; and
   iv. Is the same MSE that the Hospital would perform on any individual coming to the ED with the same signs and symptoms, regardless of the individual's ability to pay for medical care.

At CHNw, individuals that are qualified to perform an MSE at a Hospital are members of the Hospital's medical staff (physician, resident or allied health professional members) with the appropriate clinical privileges, or the employees designated in this Policy. Specifically, those individuals who may perform the MSE are as follows:

i. General medical screening exams: Emergency department physicians; emergency department allied health professionals; and other physician, resident or allied health professional members of the medical staff with appropriate clinical privileges.
ii. MSEs on pregnant women:
   1. Emergency department physicians; emergency department allied health professionals; other physician, resident or allied health professional members of the medical staff with appropriate clinical privileges; or registered obstetrical nurses with required competencies.
   2. A pregnant woman having contractions will be considered to be in true labor unless a physician certifies, after a reasonable time of observation, that the woman is in false labor. This may be done directly by the physician or by the physician in telephone consultation with another provider performing the exam. Certification done by telephone consultation must be documented as a physician's order and countersigned by the physician within 24 hours.
iii. MSEs for mental health issues:
   1. Those individuals presenting to ED may receive the MSE by emergency department physicians; emergency department allied health professionals; other physician, resident or allied health professional members of the medical staff with appropriate clinical privileges; or licensed Behavioral Health Services clinical staff in consultation with a physician.

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2. Those individuals presenting to the Behavioral Health Pavilion may receive the MSE by licensed Crisis Department clinical staff in consultation with a physician, or by a physician or allied health professional member of the medical staff with appropriate clinical privileges.

b. Stabilizing Treatment. If it is determined that the individual has an EMC, the Hospital, within the capabilities of the staff and facilities at the Hospital, must provide the treatment required to stabilize the individual's medical condition.

c. Delays in Examination or Treatment.
   i. A medical screening examination or treatment for an emergency medical condition may not delayed in order to inquire about the individual's method of payment or insurance status.
   ii. Delays in the MSE or stabilizing treatment may not occur in order to obtain pre-certification or authorization for reimbursement or treatment from any third party payer, HMO, PPO, or primary medical provider.

      i. However, reasonable registration processes may occur, including inquiring about insurance, as long as the registration process does not delay examination/treatment or unduly discourage individuals from remaining for further evaluation.
      ii. Refusing to take over an individual's care from EMS providers who have brought the individual to the Hospital DOES NOT delay or rid the Hospital of its obligations to the individual under EMTALA. This is true even if the Hospital is officially on diversionary status. Remember, once an individual is on Hospital property and has requested, or reasonably appears to be in need of, a medical screening exam for a medical condition, the Hospital's EMTALA obligations have been triggered.
      iii. A minor child can request examination or treatment for an EMC. Delay in examination or treatment the MSE by waiting for parental consent should not occur. If, after screening the minor, it is determined that no EMC is present, it is permissible to wait for parental consent before proceeding with further examination and treatment.

d. Restricting Transfer Until Stabilized. If an individual has an EMC and has not been stabilized, the individual will not be transferred unless:
   i. An "appropriate transfer" (defined below) is made;
   ii. The individual (or a legally responsible person acting on the individual's behalf) requests the transfer after being informed of the Hospital's obligations under EMTALA and the risks of transfer. This request must be in writing and must indicate that he or she is aware of the risks and benefits of the transfer; or
   iii. A physician certifies that the medical benefits reasonably expected from the provision of medical treatment at another facility outweigh the risks to the individual or, in the case of a pregnant woman, to the woman or the unborn child, from being transferred. If a physician is not physically present, a qualified medical person must make the transfer in consultation with the physician. The certification must be documented on the Transfer Form and

the physician must countersign the certification. All certifications must contain a summary of the risks and benefits to the individual.

e. Perform an "Appropriate Transfer". An appropriate transfer under EMTALA is one in which: (Utilize transfer form N556-0702 ESI# 10377)
   i. The Hospital provides medical treatment within its capacity that minimizes the risk to the individual's health, or the woman and unborn baby's health;
   ii. Is made to a facility that has available space and qualified personnel for the individual's treatment and has agreed to the transfer and to provide the appropriate medical treatment;
   iii. The Hospital sends copies of all medical records related to the presenting EMC that are available at the time of the transfer to the receiving facility, and copies of any other records not available at the time of the transfer to the receiving facility as soon a possible after the transfer;
   iv. The transfer is made through qualified personnel and transportation equipment, as required, including the use of appropriate life support measures during the transfer; and
   v. Communications to the receiving hospital are appropriate, i.e., physician to physician, nurse to nurse, therapist to therapist.

f. Responsibilities as a Recipient Hospital: If the Hospital has specialized capabilities or facilities such as neo-natal intensive care units or shock-trauma units, it may not refuse a transfer of an individual who is in need of such specialized care, as long as it has the capacity to treat the individual.

g. At Community Hospitals:
   i. A private physician may only accept a transfer as a direct admit when previous arrangements have been made by the private physician with the admitting office and only if a bed is available.
   ii. A private physician may accept transfer of an unstable patient for specialized care that is not available at the sending hospital, if the sending physician certifies that the benefits outweigh the risk. Ideally the patient is sent directly to the point of care; however, the patient may be sent to the ED if a bed is not available. For unstable patients being sent to the ED, there must be communication between the private physician and the emergency department physician.
   iii. When a potential EMTALA violation is identified, a Confidential Peer Review Report must be completed and forwarded to Quality Resources within 24 hours. (See CLN-2006, Confidential Peer Review Reports, Sentinel Events and Medical Error/ Adverse Outcomes Disclosure).

3. Limited Exceptions to EMTALA Obligations. In addition to EMTALA not applying to inpatients or to a registered outpatient who has begun a course of outpatient treatment, EMTALA does not apply, or the Hospital is considered to have met its obligations under EMTALA, if:
   a. After an MSE, the individual refuses further examination and stabilizing medical treatment. A description of the examination and/or treatment that was refused by the individual (or refused on his or her behalf) must be documented in the medical record. In addition, Hospital personnel must take all reasonable steps to get the individual to sign a written refusal which includes a statement of the risks and benefits of the examination and/or treatment.

b. The individual does not consent to an appropriate transfer after being informed of the risks and benefits of such a transfer. A description of the proposed transfer must be documented in the medical record and Hospital personnel must take all reasonable steps to get the refusal to consent (including risks and benefits associated with the transfer) in writing. If the individual refuses to consent to the transfer, he or she will be treated within the capabilities of the Hospital and Hospital personnel.
c. The Centers for Medicare and Medicaid Services issues an advisory notice that in response to a declared emergency or disaster and a declared public health emergency, that it is waiving sanctions for the redirection of individuals seeking MSEs when a state emergency preparedness plan or pandemic preparedness plan has been activated in the Hospital's area, or for inappropriate transfers arising out of the circumstances of the emergency. Hospital personnel will NOT implement changes under this section unless specifically instructed to by Hospital Administration.

4. Other Responsibilities Under EMTALA. In addition to the primary obligations listed above, the Hospitals also have other responsibilities under EMTALA.
   a. Signage.
      i. The Hospital must post signs conspicuously in the ED or in other places likely to be notices by all individuals entering the ED, as well as by individuals waiting for examination and treatment in other areas, such as entrances, admitting areas, waiting rooms and treatment areas.

      ii. These signs must (1) specify the rights individuals have with respect to examination and treatment for emergency medical conditions and labor under EMTALA; and (2) indicate that the Hospital participates in the Medicaid program.
      iii. The wording of the signs must be clear, simple and in languages that are understandable by the population served by the Hospital.

   b. Central Log: CHNw Process
      i. The Hospital must maintain a central log on each individual who comes to the ED seeking assistance and indicate in the log whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred or discharged.
      ii. Departments may use computerized or manual logs as long as all required information is captured and easily retrievable.
      iii. Logs must be maintained is such a manner as to prevent unauthorized persons from viewing patient information.
      iv. All logs must be kept in a central location in each department and be retained for at least 7 years.

   c. On-call Physicians: CHNw Process
      The Hospital must maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition.
      i. The individual physician's name and not the group name must be on the schedule.
      ii. The request for contact with any on-call physician shall be made by or at the direction of the ED/attending physician or Crisis therapist.

iii. The on-call physician, if requested, is obligated to come on site within 60 minutes to provide further examination and/or stabilizing treatment.
iv. If there is a disagreement between the ED/attending physician and the on-call specialist regarding the patient's care, the physician who is on-site providing direct care makes the final decision.
v. If an on-call physician fails to respond by ED/attending physician will contact the department chairperson for the appropriate specialty who will secure immediate coverage. A Confidential Peer Review Report must be completed.
vi. If the on-call physician's refusal or delay in treatment of the patient results in the transfer of the patient, the physician's name and address must be documented on the Transfer Form in order to comply with EMTALA. In addition, a Confidential Peer Review Report must be completed.

References:

Federal Regulations: 42 United States Code 1395dd; aka Section 1867 of Social Security Act, aka Section 1921 of Consolidated Omnibus Reconciliation Act of 1985; revised 1997; revised 1999; revised 2000; revised 2005

The EMTALA Answer Book; 2005 Edition, Moy, Mark M.: Aspen Publishers, 2005

Practice Management "EMTALA final Rule," Issued September 9, 2003, effective November 10, 2003. Prepared by the American Medical Association (AMA)

Emergency Department Compliance and Reimbursement Insider 2000

42 U.S.C § 1395dd (Examination and Treatment for Emergency Medical Conditions and Women in Labor.

State Operations Manual, Appendix V-Interpretive Guidelines. Responsibilities of Medicare Participating Hospitals in Emergency Cases. (Rev. 1, 05-21-04).

42 C.F.R. § 489.20 (2007).
73 FR 48433 (8/19/08).
68 FR 53222 (9/9/03).

Formulated by: Quality Resources
Legal Counsel

Approved by:	Quality Resources	Date:	05/12
	Legal Counsel	Date:	04/12
	Medical Staff Office	Date:	12/08
	Infection Prevention	Date:	05/12
	TIHH	Date:	5/12
Approved:	CNO Designee	Date:	05/12
Approved:	_____ Chief Operations Officer	Date:	_____

GENERAL TRANSFER CHECKLIST TOOL

- ☐ 1. Obtain physician/off site designee certification. **(NOT REQUIRED FOR PATIENT REQUEST)**
- ☐ 2. Obtain patient consent. (If patient refuses – **STOP! PATIENT DOES NOT TRANSFER.**)
- ☐ 3. Complete transfer form.
- ☐ 4. Verify, that physician/off site designee has documented risks and benefits of transfer in patient record.

- ☐ 5. Verify that physician/off site designee has contacted receiving physician, who accepts patient. Document on chart and on transfer form.

- ☐ 6. Verify receiving facility has available space and personnel and call report. Document on transfer form.

- ☐ 7. Call for appropriate mode of transportation. Document on transfer form.

- ☐ 8. Recheck vital signs immediately before transfer. Document on transfer form

- ☐ 9. For in-house, document names of all on-call physicians and consult/arrival times.

- ☐ 10. Send copies of all medical records:
  - Nursing documentation, 100%
  - Physician documentation, 100%
  - Consent
  - Transfer Form
  - X-Rays
  - Lab results
  - Other diagnostic results
  - Document in chart

- ☐ 11. For in-house, if the physician refused to care for patient:
  - Complete Transfer Form – *Physician Care Unavailable Only*
  - Call the following and document on the transfer form:
    Chief, refusing MD's department
    Chief, Medical Staff
    Administrator on-call

  - Also call:
    Risk Management within 24 hours
    Department Clinical Director or designee on-call
  - Document name and address of refusing/unavailable MD on transfer form
  - Complete Confidential Peer Review and turn in to Clinical Director

Make additional copies of this form as needed

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This form is NOT part of patient medical record.

BEHAVORIAL Health SERVICES/CRISIS INTERVENTION
TRANSFER CHECKLIST TOOL

- ☐ 1. Obtain physician certification. **(NOT REQUIRED FOR PATIENT REQUEST)**
- ☐ 2. Obtain patient consent. (If patient refuses – **STOP! PATIENT DOES NOT TRANSFER.**)
- ☐ 3. Complete transfer form.
- ☐ 4. Verify, obtained by physician consult, that the documented risks and benefits of transfer on the transfer form.
- ☐ 5. Verify that Crisis has contacted receiving physician, or Crisis team, who accepts patient. Document on chart and on transfer form.
- ☐ 6. Verify receiving facility has available space and personnel and call report. Document on transfer form.
- ☐ 7. Call for appropriate mode of transportation. Document on transfer form.
- ☐ 8. Recheck vital signs immediately before transfer, if patient in Emergency Room. Document on transfer form
- ☐ 9. Document names of all on-call physicians and consult/arrival times.
- ☐ 10. Send copies of all medical records:
  - Crisis documentation (Universal Assessment Form; Medical Questionnaire; Any information pertinent to current situation E.g., copies of previous crisis notes, progress notes, detentions, etc.)
  - If obtained, copy of release of information to receiving facility.
  - Consent
  - Transfer Form
  - Nursing documentation, 100%, if being sent form ER.
  - Physician documentation, 100%, if being sent from ER.
  - X-Rays, if being sent from ER.
  - Lab results, if being sent from ER.
  - Other diagnostic results, if being sent from ER.
- ☐ Document in chart, what specific information was sent.

11. If the physician refused to care for patient:
  - Complete Transfer Form – *Physician Care Unavailable Only*
  - Call the following and document on the transfer form:
    Chief unavailable MD's department
    Chief, Medical Staff
    Administrator on-call
  - Also call:
    Risk Management within 24 hours
    Department Clinical Director or designee on-call
  - Document name and address of refusing/unavailable MD on transfer form
  - Complete Confidential Peer Review and turn in to Clinical Director

Make additional copies of this form as needed

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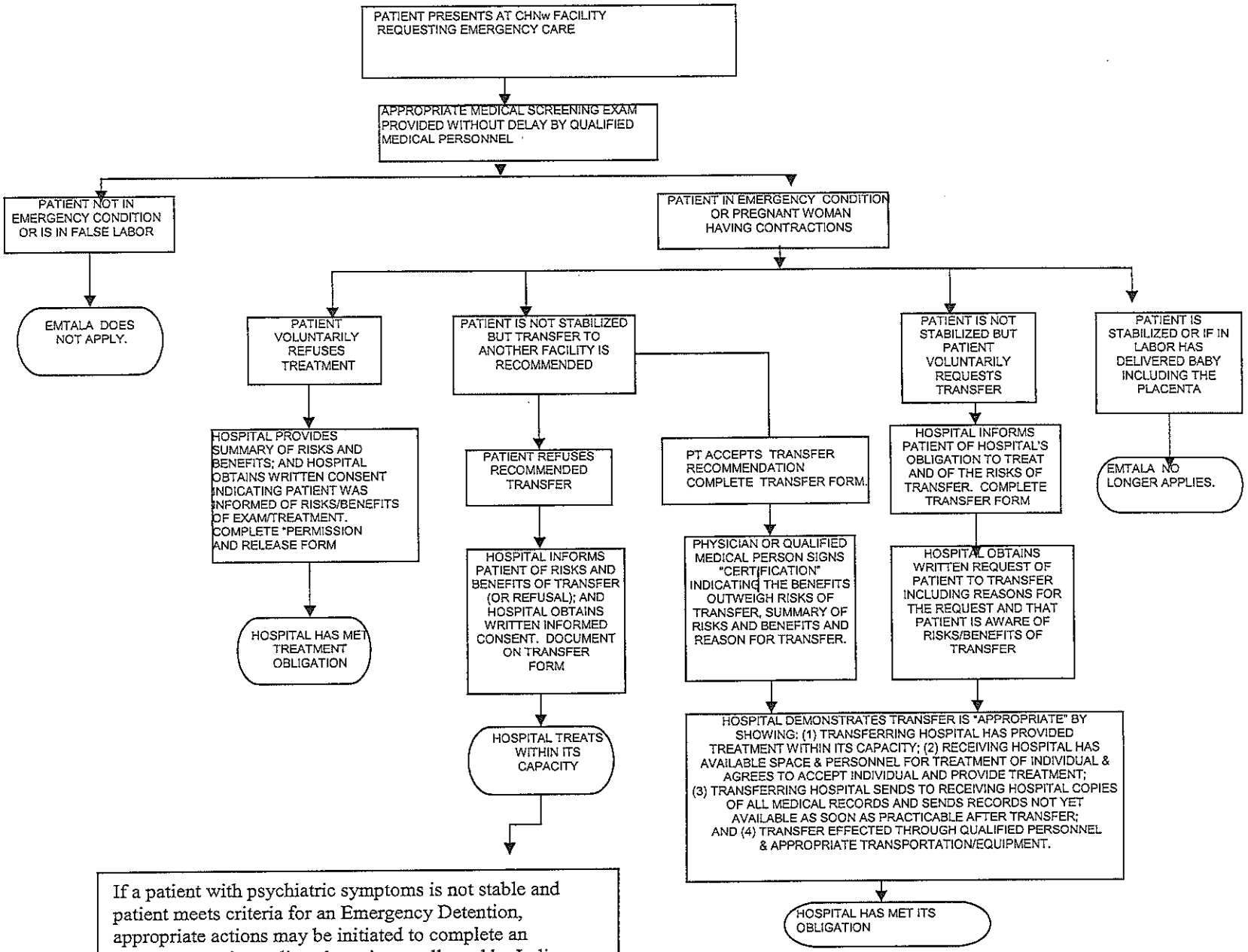
COMMUNITY HOSPITALS INDIANAPOLIS
MEDICAL SCREENING AND TRANSFER PROCESS



VII. **EMTALA Monthly Audit Process**

A. Each CHNw Emergency Department will conduct its own monthly EMTALA audits using the attached spreadsheet.

B. Minimum of five Transfer audits to be completed monthly.

C. Instructions for Spreadsheet:

Transfer paperwork completed

a. To obtain a 1 = yes

i. A transfer form must be completed and signed by patient or family member; or patient not competent to sign checked.

ii. Corresponding transfer certification completed and signed by transferring physician or patient initiated request for transfer signed (no certification required by MD).

iii. Documentation portion of form completed

1. RN to RN contact
2. Mode of travel
3. Copies of paperwork
4. Vital signs before transfer

b. To obtain a 0 = no

i. Any one thing from above not completed results in an incomplete transfer form.

2. Condition of Patient
   a. Triage category listed
      i. Emergent
      ii. Urgent
      iii. Non-urgent
3. Medical Screening Exam (MSE) Performed
   a. Yes or No
4. On-call time and response time documented
   a. Yes or No
5. On-call response time documented
   a. Yes or No
6. Peer review form completed if no response to on-call
   a. Yes or No
7. Condition stated after MSE
   a. Yes or No
8. Registered Nurse
   a. Name of RN on transfer from
9. Comments

D. If a negative trend is discovered during the EMTALA audits, then an additional ten audits will be done for that month to see if a pattern develops (i.e.: particular RN or MD) and then counsel as appropriate.

#	MR #	DOS	Transfer Paperwork Complete	Condition of Patient	Medical Screening Exam (MSE) Performed (yes/no)	Timeliness Documented	On-Call, Call Time and Response Time Documented	On-Call Response Documented	Peer Review Form Complete if no response	Condition Stated AFTER MSE	RN	Comments
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
Total Records Reviewed			0		0	0	0	0	0	0		
# Correct			0		0	0	0	0	0	0		
# of Errors			0		0	0	0	0	0	0		
Error Rate			#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		

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NS=Not Stated	1=Yes	E=Emergent	1=Yes	1=Yes	1=Yes	1=Yes	1=Yes	1=Yes
n/a=not applicable	0=No	U=Urgent N=Non-urgent	0=No	0=No	0=No	0=No	0=No	0=No

Transfer paperwork completed

A. To obtain a 1 = yes

1. A transfer form must be completed and signed by patient or family member; or patient not competent to sign checked
2. Corresponding transfer certification completed and signed by transferring physician or patient initiated request for transfer signed (no certification required by MD)
3. Documentation portion of form completed
   a. RN to RN contact
   b. Mode of travel
   c. Copies of paperwork
   d. Vital signs before transfer

B. To obtain a 0 = no

Any one thing from above not completed results in an incomplete transfer form

Condition of Patient

Triage category - emergent, urgent, and non-urgent

Medical Screening Exam (MSE) Performed

Yes or No

Timeliness Documented

??What are we considering timely? Is this timeliness of MD in performing MSE??

On-Call Time and Response Time Documented

ED MD's document times referring or attending MD called/paged.

On-Call Response Time Documented

Yes or No

Peer Review form Completed if No Response to On-Call

Yes or No

Condition Stated After MSE

Yes or No

RN

Name of RN on transfer form

Comments

What ever you like.

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COMMUNITY PHYSICIAN NETWORK – COMMUNITY PHYSICIANS OF INDIANA
PREPARATION/APPROVAL PROCESS FOR SERVICE CONTRACTS

TYPE OF CONTRACT Service Agreement – Transfer Agreement
CONTRACTOR IU Health Hospitals

INITIATION/PREPARATION:

Originator: Ron Lewis
Department: Neurology
Location: 7330 Shadeland Station
Telephone:
Responsibility for Drafting:
Outside Party Legal X

A. LEGAL
Reviewed: Approved:
By: Template Date:

RETURN TO Cathy Leonard AFTER EACH APPROVAL STEP

B. CONTRACT SUMMARY

COST $ N/A Hr./Mo./Yr. Ea.

TERM: June 1 20 14 to
*May 31 20 15

PURPOSE & DETAILS:
Renews annually in successive one-year terms
Transfer agreement between CHNw and IU Health, which includes IU Methodist, Riley and IU University hospitals, to transfer a patient from CHNw to above hospital(s) when medically necessary.

C. Is a Bus. Assoc. Agree. Req. under HIPAA Privacy Rules?
YES Included NO

D. FORECASTED
YES NO
If no, please explain:
N/A

E. PURCHASING Approved?
YES NO
If no, please explain:

F. OWNER
By: Ron Lewis
See Attached Date: 5/16/2014

J. CPN COO
By:
Tony Javorka Date: 6/25/14

K. CPN PRESIDENT
By:
Dr. Ramarao Yeleti Date: 6/24/14

J. CPE Chief Physician Executive
By:
Dr. Tim Hobbs Date: 6/25/14

K. DISTRIBUTION OF CONTRACT AFTER FULL EXECUTION:
1. Scanned copy saved to G: drive
2. Original mailed via Interoffice to Legal
4. Enter into Contract Tracking Database
5. Email scanned copy to:

Dept.	Person(s)	Date
*CPN Contract Notification		
Copy to Originator		

L. Send One Original Contract to address below:

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TRANSFER AGREEMENT
BETWEEN
COMMUNITY HEALTH NETWORK
AND
INDIANA UNIVERSITY HEALTH, INC.

THIS AGREEMENT is entered into, by and between Community Health Network, Inc. an Indiana nonprofit corporation and its subsidiaries Community Hospital South, Inc. and Community Howard Regional Health, Inc. (hereinafter "HOSPITAL"), and Indiana University Health, Inc., an Indiana nonprofit corporation (hereinafter "IU Health").

WHEREAS, HOSPITAL is the owner and operator of hospitals commonly referred to as Community Hospital North, Community Hospital East, Community Hospital South, and Community Howard Regional Health;

WHEREAS, the IU Health Academic Health Center in Indianapolis, Indiana includes IU Methodist Hospital, Riley Hospital for Children and IU University Hospital, a Level I adult trauma center at IU Methodist Hospital, a Level I pediatric trauma center at Riley Hospital, specialized research and teaching institutions, physician group practices and clinics, and other organizations related to the delivery and management of health care services; and

WHEREAS, HOSPITAL wishes to maintain a written agreement with IU Health for timely transfer of patients, including trauma patients, between their facilities;

NOW THEREFORE, in consideration of the mutual covenants contained herein, the parties agree as follows:

I. Autonomy. The parties agree that each shall continue to have the exclusive control of the management, business and properties of their respective facilities, and neither party by virtue of this Agreement assumes any liability for any debts or obligations of the other party to the Agreement.

II. Transfer of Patients. Whenever a transfer of a patient from HOSPITAL to IU Health is determined by medical staff at HOSPITAL to be medically necessary and appropriate, HOSPITAL shall notify IU Health of the proposed transfer request and provide such medical and personal patient information as necessary and appropriate to assist IU Health in evaluating and assuming the medical care of the patient upon patient's arrival. IU Health and HOSPITAL shall develop and adhere to any necessary protocols to facilitate such communication and transfer. HOSPITAL shall give notice to IU Health as far in advance as reasonably possible of a proposed transfer. HOSPITAL shall arrange for transportation of the patient. IU Health shall not be responsible for the notification and the safe transfer of the patient to the applicable IU Health facility except to the extent that IU Health is actually involved in providing the transport service.

III. Admission Priorities. Admissions to IU Health shall be in accordance with IU Health's general admission policies and procedures and in accordance with IU

Health's Medical Staff Bylaws and Rules and Regulations. IU Health is not required to give priority of admission to patients to be transferred from HOSPITAL over patients from other transferring facilities. IU Health reserves the right to decline acceptance of a HOSPITAL patient transfer if IU Health is on diversion or otherwise does not have appropriate, available resources to treat the patient.

IV. Medicare Participation. During the term of this Agreement, and any extensions thereof, HOSPITAL and IU Health agree to meet and maintain all necessary Medicare Conditions of Participation and coverage so as to remain approved providers thereunder. HOSPITAL and IU Health shall each be responsible for complying with all applicable federal and state laws.

V. Compliance. HOSPITAL and IU Health agree that any services provided under this Agreement will comply in all material respects with all federal and state mandated regulations, rules or orders applicable to IU Health and/or HOSPITAL, including, but not limited, to regulations promulgated under Title II, Subtitle F of the Health Insurance Portability and Accountability Act (Public Law 104-91) - "HIPAA" and Title XVIII, Part D of the Social Security Act (42 U.S.C. § 1395dd) – "EMTALA". Furthermore, HOSPITAL and IU Health shall promptly amend the Agreement to conform with any new or revised legislation, rules and regulations to which HOSPITAL and/or IU Health is subject now or in the future including, without limitation, the Standards of Privacy of Individually Identifiable Health Information or similar legislation (collectively, "Laws") in order to ensure that HOSPITAL and IU Health are at all times in conformance with all Laws. If, within ninety (90) days of either party first providing notice to the other of the need to amend the Agreement to comply with Laws, the parties acting in good faith, are (i) unable to mutually agree upon and make amendments or alterations to this Agreement to meet the requirements in question, or (ii) alternatively, the parties determine in good faith that amendments or alterations to the requirements are not feasible, then either party may terminate this Agreement immediately.

VI. Interchange of Information and Medical Records. HOSPITAL and IU Health agree to transfer medical and other information and medical records which may be necessary or useful in the care and treatment of patients transferred hereunder as required and permitted by all applicable federal and state laws. Such information shall be provided by HOSPITAL and IU Health in advance, when possible, and where permitted by applicable law. HOSPITAL shall commit to subscribing to a spoke connection to the IU Health Radiology Cloud in order to enhance the timely transmission and reading of diagnostic images at IU Health for transferred patients, particularly trauma patients.

VII. Consent to Medical Treatment. To the extent available, HOSPITAL agrees to provide IU Health with information and assistance, which may be needed by, or helpful to, IU Health in securing consent for medical treatment for the patient.

VIII. Transfer of Personal Effects and Valuables. Procedures for effecting the transfer of personal effects and valuables of patients shall be developed by the parties and subject to the instructions of the attending physician and of the patient and his or her family where appropriate. A standard form shall be adopted and used for documenting the transfer of the patient's personal effects and valuables. HOSPITAL shall be responsible for all personal effects and valuables until such time as possession is accepted by IU Health.

IX. Financial Arrangements. Each party shall each be responsible for billing and collecting for the services which it provides to the patient transferred hereunder from the patient, third party payor or other sources normally billed by each institution. Neither party shall assume any liability by virtue of this Agreement for any debts or other obligations incurred by the other party to this Agreement.

X. Return Transfer of Patients. HOSPITAL will accept transferred patients back from IU Health when medically appropriate and in the best interests of the patient.

XI. Professional and General Liability Coverage. Throughout the term of this Agreement and for any extension(s) thereof, HOSPITAL and IU Health shall each maintain professional and general liability insurance coverage with limits reasonably acceptable to the other party. Each party shall provide the other party with proof of such coverage upon request. HOSPITAL and IU Health shall each maintain qualification as a qualified health care provider under the Indiana Medical Malpractice Act, as amended from time to time, including, but not limited to, proof of financial responsibility and payment of surcharge assessed on all health care providers. Each party shall provide the other party with proof of such qualification upon request.

XII. Indemnification.

12.1. HOSPITAL Indemnification. HOSPITAL agrees that it will indemnify and hold harmless IU Health, its officers, agents, and employees from any loss, cost, damage, expense, attorney's fees, and liability by reason of bodily injury, property damage, or both of whatsoever nature or kind, arising out of or as a result of the sole negligent act or negligent failure to act of HOSPITAL or any of its agents or employees.

12.2. IU Health Indemnification. IU Health agrees that it will indemnify and hold harmless HOSPITAL, its officers, agents, and employees from any loss, cost, damage, expense, attorney's fees, and liability by reason of personal injury or property damage of whatsoever nature or kind, arising out of or as a result of the sole negligent act or failure to act of IU Health or any of its employees or agents.

XIII. Term and Termination.

13.1. Term. The term of this Agreement is for a period of one (1) year from the date hereof, with an automatic renewal of successive one (1) year periods

unless on or before sixty (60) calendar days prior to the expiration of the annual term, one party notifies the other, in writing, that the Agreement is not to be renewed, in which event the Agreement will be terminated at the expiration of the then current annual term.

13.2. Termination.

13.2-1 Either party may terminate this Agreement with or without cause at any time by providing written notice to the other party at least sixty (60) days in advance of the desired termination date.

13.2-2 The Agreement shall terminate immediately and automatically if (i) either IU Health or HOSPITAL has any license revoked, suspended, or nonrenewed; or (ii) either party's agreement with the Secretary of Health and Human Services under the Medicare Act is terminated.

13.2-3 Except as provided for elsewhere in this Agreement, either party may declare this Agreement terminated if the other party does not cure a default or breach of this Agreement within thirty (30) calendar days after receipt by the breaching party of written notice thereof from the other party.

XIV. Notices. Notices or communication herein required or permitted shall be given the respective parties by registered or certified mail, documented courier service delivery or by hand delivery at the following addresses unless either party shall otherwise designate its new address by written notice:

HOSPITAL	IU Health
Community Health Network 7330 Shadeland Station Indianapolis, IN 46256	Indiana University Health, Inc. 340 West 10th Street, Suite 6100 Indianapolis, IN 46206-1367
Attention: President/CEO General Counsel	Attention: President/CEO General Counsel

XV. Assignment. Assignments of this Agreement or the rights or obligations hereunder shall be invalid without the specific written consent of the other party herein.

XVI. Nonexclusive Clause. This is not an exclusive Agreement and either party may contract with other institutions for the transfer of patients while this Agreement is in effect.

XVII. Governing Law. This Agreement shall be construed and governed by the laws of the State of Indiana. The venue for any disputes arising out of this Agreement shall be Marion County, Indiana.

XVIII. Waiver. The failure of either party to insist in any one or more instance upon the strict performance of any of the terms or provisions of this Agreement by the other party shall not be construed as a waiver or relinquishment for the future of any such term or provision, but the same shall continue in full force and effect.

XIX. Severability. If any provision of this Agreement is held by a court of competent jurisdiction to be unenforceable, invalid or illegal, such unenforceability, invalidity or illegality shall not affect any other provision hereof, and this Agreement shall be construed as if such provision had never been contained herein.

XX. Section and Other Headings. The article and other headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

XXI. Amendments. This Agreement may be amended only by an instrument in writing signed by the parties hereto.

XXII. Entire Agreement. This Agreement is the entire Agreement between the parties and may be amended or modified only by a written amendment hereto duly executed by both parties.

XXIII. Execution. This Agreement and any amendments thereto shall be executed in duplicate copies on behalf of HOSPITAL and IU Health by an official of each, specifically authorized by its respective Board to perform such executions. Each duplicate copy shall be deemed an original, but both duplicate originals together constitute one and the same instrument.

IN WITNESS WHEREOF, the duly authorized officers and representatives of HOSPITAL and IU Health have executed this Agreement the 1st day of June, 2014.

HOSPITAL:

COMMUNITY HEALTH NETWORK

By: Timothy Holtzen

Title: Chief Physician Executive

AND

IU HEALTH:

INDIANA UNIVERSITY HEALTH, INC.

By:

Jeffrey Sperring, M.D.
President, IU Health Methodist, Riley and University Hospitals

PATIENT TRANSFER AGREEMENT

This Patient Transfer Agreement ("Agreement") is between the Health and Hospital Corporation of Marion County d/b/a Eskenazi Health and Community Health Network and its subsidiaries Community Hospital South, Inc. and Community Howard Regional Health, Inc. (hereinafter "Hospital"). Eskenazi Health and Hospital are collectively referred to as "Institutions."

Eskenazi Health is a comprehensive public health care system with facilities and services including a hospital, outpatient clinics, inpatient and outpatient mental health services, Level I Trauma Center and the Richard M. Fairbanks Burn Center.

Community Health Network, Inc. and its subsidiaries operate acute care hospitals commonly referred to as Community Hospital East, Community Hospital North, Community Hospital South and Community Howard Regional Health (collective "Hospital")

Eskenazi Health and Hospital have determined that it would be in the best interest of patient care and would promote the optimum use of facilities to enter into a transfer agreement for transfer of patients between the respective Institutions.

Eskenazi Health and Hospital therefore agree as follows:

1. *Term.* This Agreement shall become effective beginning June 1, 2014 ("Effective Date") and shall remain in effect for a period of one year from the Effective Date, upon which date the Agreement will automatically renew for additional one-year periods.

2. ***Purpose of Agreement.*** Each Institution agrees to transfer to the other Institution and to receive from the other Institution patients in need of the care provided by their respective Institutions for the purpose of providing improved patient care and continuity of patient care.

3. ***Patient Transfer to Eskenazi Health.*** The request for transfer of a patient from Hospital to Eskenazi Health shall be initiated by the patient's attending physician. Any authorized member of Eskenazi Health's medical staff may authorize a transfer when the patient in question needs Level 1 Trauma Services, interventional radiology, or the services of the Burn Unit if Eskenazi Health has an appropriate bed available and is not on diversion. All other Hospital requests for patient transfers to Eskenazi Health shall be referred to the Bed Control Coordinator/House Supervisor. Prior to moving the patient, Hospital must receive confirmation from Eskenazi Health that it can accept the patient, and there must be direct communication between the referring and receiving physician. Patients shall be delivered to Sidney & Lois Eskenazi Hospital.

4. ***Patient Transfer to Hospital.*** The request for transfer of a patient from Eskenazi Health to Hospital shall be initiated by the patient's attending physician. Any

authorized member of Hospital's medical staff may authorize a transfer if Hospital has an appropriate bed available and is not on diversion. Prior to moving the patient, Eskenazi Health must receive confirmation from Hospital that it can accept the patient, and there must be direct communication between the referring and receiving physician. Patients shall be delivered to Hospital's Emergency Department.

5. ***Patient Records and Personal Effects.*** Each of the Institutions agrees to adopt standard forms of medical and administrative information to accompany the patient from one Institution to the other. The information shall include, when appropriate, the following:

A. Patient's name, address, hospital number, and age; name, address, and telephone number of the patient's legal guardian (if applicable);

B. Patient's third-party billing data;

C. History of the injury or illness;

D. Condition on admission;

E. Vital signs prehospital, during stay in emergency department, and at time of transfer;

F. Treatment provided to patient; including medications given and route of administration;

G. Laboratory and X-ray findings, including films;

H. Fluids given, by type and volume;

I. Name, address, and phone number of physician referring patient;

J. Name of physician in receiving Institution to whom patient is to be transferred; and

K. Name of physician at receiving Institution who has been contacted about patient.

L. Specialized needs and dietary restrictions.

Each Institution shall supplement the above information as necessary for the maintenance of the patient during transport and treatment upon arrival at the receiving Institution, and the Institutions shall work together to reduce repetition of diagnostic tests. Transfers of Protected Health Information (PHI) shall comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In addition, each Institution agrees to adopt a standard form to inventory a patient's personal effects and valuables that shall accompany the patient during transfer. The records described above shall be placed in the custody of the person in charge of the transporting medium who shall sign a receipt for the medical records and the patient's valuables and personal effects and in turn shall obtain a receipt from the receiving Institution when it receives the records and the patient's valuables and personal effects. The transferring Institution shall bear responsibility for the loss of the patient's personal effects and valuables unless it can produce an authorized receipt for the personal effects and valuables from the accepting Institution.

6. ***EMTALA Compliance and Transfer Consent.*** The transferring Institution shall have responsibility for meeting the requirements for an "appropriate transfer" under the Emergency Medical Treatment and Active Labor Act (EMTALA), if applicable. The transferring Institution is responsible for obtaining the patient's consent to the transfer to the other Institution prior to the transfer, if the patient is competent. If the patient is not competent, the transferring Institution shall obtain a family member's consent; if such consent is not possible, the consent of the patient's physician shall be obtained by the transferring Institution.

7. ***Payment for Services.*** The patient is primarily responsible for payment for care received at either Institution. Each Institution shall be responsible only for collecting its own payment for services rendered to the patient. No clause of this Agreement shall be interpreted to authorize either Institution to look to the other Institution to pay for services rendered to a patient transferred by virtue of this Agreement, except to the extent that such liability would exist separate and apart from this Agreement.

8. ***Transportation of Patient.*** The transferring Institution shall have responsibility for arranging transportation of the patient to the other Institution, including selection of the mode of transportation and providing appropriate health care practitioner(s) to accompany the patient if necessary. The receiving Institution's responsibility for the patient's care shall begin when the patient is admitted, either as an inpatient or an outpatient, to that Institution.

9. ***Advertising and Public Relations.*** Neither Institution shall use the name of the other Institution in any promotional or advertising material unless review and approval of the intended advertisement first shall be obtained from the party whose name is to be used. Both Institutions shall deal with each other publicly and privately in an atmosphere of mutual respect and support, and each Institution shall maintain good public and patient relations and efficiently handle complaints and inquires with respect to transferred or transferring patients.

10. ***Independent Contractor Status.*** Both Institutions are independent contractors. Neither Institution is authorized or permitted to act as an agent or employee of the other. Nothing in this Agreement shall in any way alter the freedom enjoyed by

either Institution, nor shall it in any way alter the control of the management, assets, and affairs of the respective Institutions. Neither party, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other party to this Agreement.

11. ***Liability.*** Hospital shall save, indemnify, and hold Eskenazi Health harmless of and from any and all liability, loss, costs, and expenses incurred directly or indirectly from any acts, errors, or omissions by Hospital, its agents, employees or invitees from any cause arising out of or relating to Hospital's performance under this Agreement. Any obligation of Hospital to save and hold Eskenazi Health harmless is limited in substance by statutes designed to protect and limit the exposure and liability of Hospital as a qualified health care provider under the Indiana Medical Malpractice Act.

Eskenazi Health shall save, indemnify, and hold Hospital harmless of and from any and all liability, loss, costs, and expenses incurred directly or indirectly from any acts, errors, or omissions by Eskenazi Health, its agents, employees or invitees from any cause arising out of or relating to Eskenazi Health's performance under this Agreement.

Any obligation of Eskenazi Health to save and hold Hospital harmless is limited in substance by statutes designed to protect and limit the exposure and liability of Eskenazi Health as an instrumentality of the State of Indiana under the Indiana Tort Claims Act and as a qualified health care provider under the Indiana Medical Malpractice Act.

12. ***Exclusion.*** Institutions represent and warrant that the Institution, its employees, directors, officers, subcontractors, and agents are not under sanction and/or have not been excluded from participation in any federal or state program, including Medicare or Medicaid.

13. ***Insurance.*** Each Institution shall maintain at all times throughout the term of this Agreement commercially reasonable insurance, including but not limited to, comprehensive general liability insurance, professional liability insurance, and property damage insurance. Upon request, each Institution shall provide the other with written documentation evidencing such insurance coverage.

14. ***Termination.***

A. *Voluntary Termination.* This Agreement shall be terminated by either party for any reason, by giving thirty (30) days' written notice of its intention to withdraw from this Agreement, and by ensuring the continuity of care to patients who already are involved in the transfer process. To this end, the terminating party will be required to meet its commitments under the Agreement to all patients for whom the other party has begun the transfer process in good faith.

B. *Involuntary Termination.* This Agreement shall be terminated immediately upon the occurrence of any of the following:

1. Either Institution is destroyed to such an extent that the patient care provided by such Institution cannot be carried out adequately;

2. Either Institution loses its license or accreditation;

3. Either Institution no longer is able to provide the service for which this Agreement was sought; and

4. Either Institution is in default under any of the terms of this Agreement.

5. Either Institution have been debarred, excluded or otherwise determined ineligible from participation in any federal or state program, including Medicare and Medicaid.

14. ***Nonwaiver.*** No waiver of any term or condition of this Agreement by either party shall be deemed a continuing or further waiver of the same term or condition or a waiver of any other term or condition of this Agreement.

15. ***Governing Law.*** This Agreement is governed by the laws of the State of Indiana. Any litigation arising out of this Agreement shall be brought in a court located in Marion County, Indiana.

16. ***Assignment.*** This Agreement shall not be assigned in whole or in part by either party without the express written consent of the other party.

17. ***Invalid Provision.*** In the event that any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the parties in the same manner as if the invalid or unenforceable provision were not a part of this Agreement.

18. ***Amendment.*** This Agreement may be amended at any time by a written agreement signed by the parties.

19. ***Notice.*** Any notice required or allowed to be given under this Agreement shall be deemed to have been given upon deposit in the United States mail, registered or certified, with return receipt requested. Any and all notices are to be addressed as follows:

ESKENAZI HEALTH:
Eskenazi Health
Attn: Legal Department
720 Eskenazi Avenue
FOB 5th Floor

3604

Indianapolis, IN 46202

COMMUNITY HEALTH NETWORK:
Community Hospital Network
Attn: Legal Department
7330 Shadeland Station
Indianapolis, IN 46256

20. ***Entire Agreement.*** This Agreement constitutes the entire agreement between the parties and contains all of the agreements between them with respect to its subject matter and supersedes any and all other agreements, either oral or in writing, between the parties to the Agreement with respect to the subject matter of this Agreement.

21. ***Binding Agreement.*** This Agreement shall be binding upon the successors or assigns of the parties.

22. ***Authorization for Agreement.*** The execution and performance of this Agreement by each Institution has been duly authorized by all necessary laws, resolutions, or corporate actions, and this Agreement constitutes the valid and enforceable obligations of each Institution in accordance with its terms.

Eskenazi Health and Hospital are each signing this Agreement on the date stated below that party's signature.

THE HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY D/B/A ESKENAZI HEALTH

Lisa Harris MD

Lisa Harris, CEO and Medical Director

Date: 6/24/14

COMMUNITY HEALTH NETWORK

By: Timothy D. Hellmann

Title: Chief Physician Exec.

Date: 6/27/14

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 11

Trauma OR, Staff and Equipment

11. "**Trauma Operating Room, staff, and equipment.** There must be prompt availability of a Trauma Operating Room (OR), an appropriately staffed OR team, essential equipment (including equipment needed for a craniotomy) and anesthesiologist services 24 hours per day. The application must also include a list of essential equipment available to the OR and its staff."

Narrative Response and Discussion

The requirements of section 11 are met with a letter of commitment from Community Hospital South's Chief of Anesthesiology affirming 24 hour availability of anesthesiologist services. Also included is the OR staff and equipment list for the Operating Rooms.

3660

Community
Health Network

Community Hospital South
Emergency Department
1402 E. County Line Road
Indianapolis, Indiana 46227-0963
317-887-7200 (tel)
eCommunity.com

June 16, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of the correspondence is to inform the committee that I serve as Anesthesiologist Chairman. I am pleased to support Community Hospital South's effort to complete "in the process" Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I further understand that my role is to ensure that a qualified anesthesiologist is promptly available twenty – four hours per day. I attest that we have adequate anesthesia equipment to provide trauma services including neurosurgical procedures.

An anesthesiologist liaison will attend at least 50% of the PIPS committee meetings and actively participate in performance improvement process.

Respectfully,

Andrew Corsaro, M.D.
Department Chairman
Department of Anesthesia

Edward Diekhoff M.D., F.A.C.S
Trauma Medical Director

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Community Health Network

Community Hospital South
1402 E. County Line Road
Indianapolis, IN 46227
eCommunity.com

Community Hospital South
Operating Room Equipment

The equipment listed below is available 24 hours per day.

- Glide-scope for video intubation
- Difficult Airway Cart with brochoscopy
- Monitors for basic vital signs and invasive monitoring
- BIS Monitors
- Bair Hugger-patient warming
- Cautery-Monopolar
- Cautery-Bi-polar
- Suction
- Tourniquets
- Headlights
- Hotline Fluid Warmer
- IV Pumps
- C-arm
- Fluoroscopy
- Power Injector
- Portable x-ray
- X-ray aprons
- PACS system
- Crash Cart with bronchoscopy
- Cell saver
- Sponge counter system
- Bladder Scanner
- **OR Tables**
  - ✓ Hana Table (Hip Fractures)
  - ✓ Axis Jackson Table
  - ✓ Jackson Table with flat top frame
  - ✓ Wilson Frame (regular OR table)
  - ✓ Wilson Frame-Spine & Craniotomy Procedures
  - ✓ OSI Hydraulic Floating Table
  - ✓ Hand Table
- **Orthopedics**
  - ✓ Drills
  - ✓ Basic Instruments
  - ✓ Specialized Instruments
  - ✓ Implant Sets
  - ✓ Major and Minor Instrumentation
- **Neurosurgical**
  - ✓ Basic and Specialized Instrumentation
  - ✓ Implants
  - ✓ Midas Rex Drills
  - ✓ Navigation system and O-arm
  - ✓ Aneurysms Clips
  - ✓ Camino Monitor
  - ✓ Ventriculosotomy Set
  - ✓ Mayfield Head Holder

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April 2014

March 2014

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

April 2014

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27	28	29	30			

May 20[illegible]

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18	19	20	21	22	23	24
25	26	27	28	29	30	31

CALL

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
31 [illegible]		1 PATTON	2 NGO	3 [illegible] Sukay	4 LABARGE	5 LABARGE
		7:00 AM Ngo B/U	7:00 AM ~~Stuart B/U~~ Mapalad B/U	7:00 AM ~~Laberge B/U~~ [illegible] B/U Laberge B/U Patron (out by 4:30 Plse)	7:00 AM ~~Popovic B/U~~ Sukay [illegible] B/U Mapalad B/U	7:00 AM ~~Popovic B/U~~ Sukay [illegible] Mapalad B/U
		Ops Mtg - 7am				
6 LABARGE	7 [illegible] Sukay	8 PARKER	9 MCGEE	10 PATRON	11 STRAIN	12 STRAIN
7:00 AM ~~Popovic B/U~~ Sukay [illegible] Mapalad B/U	7:00 AM ~~Parker B/U~~ Mapalad Burton B/U	7:00 AM McGee B/U Corsaro/Patel - 4-1epm mtg @ Comm. North Corsaro + McGee 7-8am meeting	7:00 AM Patron B/U	7:00 AM ~~[illegible] Strain B/U~~ Sukay	7:00 AM ~~Sukay B/U~~ LaBarge B/U	7:00 AM ~~Sukay B/U~~ LaBarge B/U
13 STRAIN	14 [illegible]	15 MAPALAD	16 [illegible] Sukay	17 NGO	18 [illegible]	19 [illegible]
7:00 AM ~~Sukay B/U~~ LaBarge B/U	7:00 AM Mapalad B/U	7:00 AM Stuart B/U	7:00 AM Ngo B/U	7:00 AM ~~Burton B/U~~ Corsaro B/U	7:00 AM ~~Laberge B/U~~ ~~Sukay B/U~~ Patron B/U	7:00 AM ~~Laberge B/U~~ ~~Sukay B/U~~ Patron B/U
20 [illegible]	21 PATTON [illegible]	22 POPOVICH	23 [illegible] Sukay	24 MCGEE	25 [illegible]	26 [illegible]
7:00 AM ~~Laberge B/U~~ ~~Sukay B/U~~ Patron B/U	7:00 AM Popovic B/U	7:00 AM Parker B/U	7:00 AM McGee B/U meeting until 9a Corsaro, Patel, & Strain	7:00 AM ~~Corsaro B/U~~ ~~Popovic~~ Burton B/U CORSARO - mtg 7a-8a	7:00 AM ~~7:00 AM Strain B/U~~ ~~Sukay~~ Sukay	7:00 AM ~~Strain B/U~~ ~~Strain~~ Sukay
27 [illegible]	28 [illegible] Sukay	29 [illegible]	30 MAPALAD			
7:00 AM ~~Strain B/U~~ ~~Strain~~ Sukay	7:00 AM ~~Sukay B/U~~ Popovic Patron B/U	7:00 AM Mapalad B/U	7:00 AM ~~Patron B/U~~ Popovic B/U			

May 2014

April 2014

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27	28	29	30			

May 2014

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4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June 2014

S	M	T	W	T	F	S
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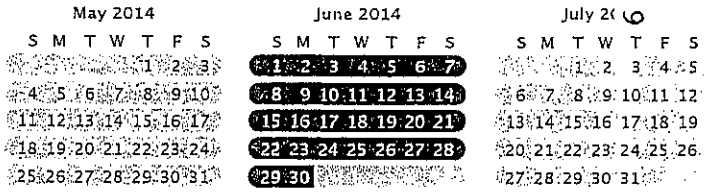
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

CALL

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
27	28	29	30	1 PATRON Popovic 7:00 AM ~~Ngo B/U~~ Sukay B/U Board Mtg - 7am	2 NGO Sukay 7:00 AM Stuart B/U	3 NGO Sukay 7:00 AM Stuart B/U
4 NGO Sukay 7:00 AM Stuart B/U	5 STUART 7:00 AM Labarge B/U	6 LABARGE 7:00 AM Popovic B/U ~~Patel/Corsaro 7-8 meeting~~	7 POPOVIC 7:00 AM Parker B/U	8 PARKER 7:00 AM ~~McGee~~ B/U LaBarge B/U Patron - Surgery @ end of day	9 MCGEE LABARGE 7:00 AM Corsaro B/U	10 MCGEE LABARGE 7:00 AM Corsaro B/U OFF
11 MCGEE LABARGE 7:00 AM Corsaro B/U	12 CORSARO 7:00 AM Strain B/U Board Mtg 7AM	13 STRAIN 7:00 AM Sukay B/U Patel/Corsaro-7-8 meeting 7-8am meeting McGee VEI Board Mtg	14 SUKAY NGO 7:00 AM Mapalad B/U McGee out by 3:30	15 MAPALAD 7:00 AM ~~Patron~~ B/U Popovic B/U	16 PATRON Popovic 7:00 AM McGee B/U Strain - 7:30-8:30 Mtg	17 PATRON Popovic 7:00 AM ~~McGee B/U~~ Corsaro B/U
18 PATRON Popovic 7:00 AM McGee B/U	19 MCGEE 7:00 AM ~~Burton B/U~~ Labarge ~~Stephan B/U~~ Patel Dinner 5:30	20 PATRON Sukay 7:00 AM ~~Labarge~~ STRAIN 9-4 Patel	21 LABARGE 7:00 AM Popovic B/U	22 POPOVIC 7:00 AM Ngo B/U Patron out by noon/12:30 if poble.	23 NGO 7:00 AM ~~Mapalad B/U~~ Corsaro Sukay B/U P.	24 MAPALAD 7:00 AM ~~Ngo B/U~~ Burton B/U SUKAY
25 MAPALAD 7:00 AM ~~Ngo B/U~~ Burton B/U	26 MAPALAD 7:00 AM Ngo B/U Capitol Grille	27 CORSARO 7:00 AM ~~Strain B/U~~ PATRON B/U	28 STRAIN Patron 7:00 AM ~~Sukay B/U~~ Strain	29 SUKAY 7:00 AM Parker B/U Patron out by noon please CORSARO - mtg 4p-5p	30 PARKER LABARGE 7:00 AM ~~Patron B/U~~ Sukay B/U Cosaro B/U	31 PARKER LABARGE 7:00 AM ~~Patron B/U~~ Sukay B/U

June 2014



CALL

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 PARKER 7:00 AM ~~Patron B/U~> Sakay B/U	2 PATRON Sakay 7:00 AM Ngo B/U	3 McGee 7:00 AM Stuart B/U Corsaro-3-4p meeting	4 STUART 7:00 AM Labarge B/U	5 LABARGE 7:00 AM ~~Popovic~~ B/U PATRON B/U Corsaro-3-4pm meeting	6 POPOVIC Patron 7:00 AM ~~Mapalad B/U~> Popovic B/U Strain - 7am meeting	7 POPOVIC Patron 7:00 AM ~~Mapalad B/U~> Popovic B/U
8 POPOVIC Patron 7:00 AM ~~Mapalad B/U~> Popovic B/U	9 Popovic 7:00 AM McGee B/U	10 Ngo 7:00 AM ~~Corsaro B/U~> Sakay B/U 7-8am meeting M'Gee	11 CORSARO Corsaro 7:00 AM Strain B/U Sakay	12 STRAIN 7:00 AM ~~Sakay B/U~> Mapalad	13 SAKAY 7:00 AM ~~Parker~~ B/U ~~Burton B/U~> Strain McGee 8/8:30 start Epos	14 ~~PARKLAD SUKAY~~ MAPALAD Dr. 7:00 AM ~~Parker~~ B/U Burton BU C-1 - 3pm-noon Dr. Ross Surg
15 SUKAY 7:00 AM ~~Parker~~ B/U Burton BU until noon- C-1-	16 Corsaro 7:00 AM ~~Patron~~ B/U McGee B/U	17 PATRON 7:00 AM Ngo B/U	18 NGO 7:00 AM Burton B/U Patron-out by 1:30	19 BURTON Sakay 7:00 AM ~~Labarge B/U~> McGee B/U Corsaro - 3-4:30 meeting Patron - out by 3:15 (4pm closing)	20 LABARGE McGee 7:00 AM Popovic B/U	21 LABARGE McGee 7:00 AM Popovic B/U
22 LABARGE McGee 7:00 AM Popovic B/U	23 POPOVIC 7:00 AM Parker B/U	24 PARKER 7:00 AM McGee B/U	25 MCGEE 7:00 AM Corsaro B/U	26 Parker 7:00 AM Strain B/U 7am-8am- corsaro-meeting	27 STRAIN 7:00 AM ~~Sakay B/U~> Popovic Corsaro - 4pm meeting	28 STRAIN 7:00 AM ~~Sakay B/U~> Popovic
29 STRAIN 7:00 AM ~~Sakay B/U~> Popovic	30 Popovic 7:00 AM Mapalad B/U					

CHS Surgical Services Call List

Date: _____

CALL COORDINATOR: person is to be called first and is responsible for calling in all on-call personnel.
OPERATOR: at a physician's request, please release the Call Coordinator's contact information.

Coordinator

Name	Time	1st Contact #	Alternate #	Pager

Surgery Staff

Call 1 Name	Time	1st Contact #	Alternate #	Pager
Call 2				

Recovery Staff

Call 1 Name	Time	1st Contact #	Alternate #	Pager
Call 2				
Late Stay				

Endoscopy Staff

Call 1 Name	Time	1st Contact #	Alternate #	Pager
Call 2				

Anesthesia	1st Contact #	Alternate #	Pager
P. Burton, MD			
A. Corsaro, MD			
S. LaBarge, MD			
J. Mapalad, MD			
R. McGee, MD			
D. Ngo, MD			
A. Parker, MD			
B. Patel, MD			
R. Patron, MD			
R. Popovic, MD			
C. Strain, MD			
J. Stuart, MD			
C. Sukay, MD			

Anesthesia Call_____ Anesthesia Back-up_____

Surgical Services Leadership

Patrick Beaupre			
Jill Thomas			
Mark Walke			

CETECH, Cell Saver: Mark Gilpin cell **pager** **; Sean Hoskins**

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Revised: 6/17/2014

	530020-OR									
1	Best	W	Christopher	1	5/9/11	CST	8/1/15	n/a	n/a
2	Browning	L	Kylie	0.6	8/15/05	2/7/14 CST	2/1/15	n/a	n/a
3	Caudill	A	Julie	1	6/10/13	RN	3/1/16	9/1/15	5/1/16
4	Collier	M	James	1	6/28/10	RN	3/1/15	3/1/15	5/1/15
5	Dobbs	S	Erika	1	5/13/13	RN	5/1/16	7/1/15	5/1/16
6	Edwards	E	Christopher	prn	5/6/13	RN	7/1/15	10/1/15	
7	Frost	H	Ted	prn	7/24/94	RN	2/1/15	11/1/15	
8	Fultz	L	Jetta	0.75	5/17/04	9/1/11-CST	10/1/15	n/a	n/a
9	Hines	M	Lauree	1	8/12/96	CST	4/1/15	n/a	n/a
10	Hoeping	A	Melissa	1	2/4/13	RN	9/1/15	9/1/14	8/1/15
11	Huddleston	L	Julie	1	12/5/11	RN	2/1/15	3/1/15	
12	Huffman	W	Marcia	prn	9/1/92	RN	3/1/15	4/30/15	
13	Hurst	J	Melanie	0.9	3/14/11	RN	4/1/15	4/30/15	5/1/16
14	Hutson	L	Tessa	prn	5/5/14	RN	5/1/15	9/1/15	
15	Kipfer	L	Carina	1	7/14/04	RN	11/1/15	3/1/16	
16	Madden	A	Scott	1	05/1988	n/a	3/1/15	n/a	n/a
17	Manowitz	A	Cynthia	prn	12/7/06	CST	4/1/16	n/a	n/a
18	Mobley	S	Kimberly	1	8/30/10	CST	8/1/15	n/a	n/a
19	Munoz	A	Kelly	1	5/26/98	RN	3/1/15	4/1/16	
20	Payne	D	Cherise	1	7/1/13	12/8/16-CST	4/1/15	n/a	n/a
21	Perry	B	Chelsy	0.9	11/12/10	RN	11/1/15	1/1/16	5/1/16
22	Robertson *	L	Diana	1	4/2005	RN	11/1/15	2/1/16	1/1/16
23	Storm	A	Danielle	1	12/5/11	RN	7/1/15	3/1/15	
24	Yeager	A	Julie	0.6	07/1993	RN	11/1/15	7/1/15	
	530070-PACU/POCU								
25	Burris		Kenneth	1	1/5/09	RN	11/1/15	2/1/16	8/1/15
26	Cala	J	Susan	0.8	6/1/92	RN	7/1/15	1/1/16	1/1/16
27	Case	R	Nikki	0.8	05/2002	RN	3/1/15	1/1/15	5/1/16
28	Cox	J	Pamela	0.9	8/23/82	RN	2/1/15	1/1/15	1/1/16
29	Franklin	D	Michelle	1	6/18/12	RN	9/1/15	9/1/15	9/1/15
30	Hamilton		Michelle	1	3/7/11	RN	10/1/15	2/1/16	10/1/15
31	Hendley		Bess Anne	1	5/8/90	RN	11/1/15	9/1/15	10/1/15
32	Holland	R	Cynthia	1	12/17/12	RN	11/1/15	8/1/15	4/1/15
33	Kocher	L	Maureen	0.6	05/1983	RN	11/1/15	3/1/15	2/1/16
34	Lobdell-Monroe	L	Donna	0.9	08/1990	RN	2/1/15	7/1/15	2/1/16
35	McCorkle	J	Barbara	0.75	10/2005	RN	2/1/15	7/1/15	2/1/15
36	Monnett-Kelsey	R	Jill	prn	4/15/13	RN	5/1/16	8/1/15	8/1/15
37	Patel	G	Alisha	prn	4/3/14	RN	5/1/16	5/1/16	5/1/16
38	Patterson	L	Ashley	1	3/7/11	RN	4/1/15	5/1/16	10/1/15
39	Peters	R	Dena	prn	10/31/11	RN	2/1/15	2/1/15	8/1/15
40	Strain	N	Brandi	prn	12/1995	RN	2/1/15	4/1/15	2/1/16
41	Wilson	J	Aggie	prn	5/17/04	RN	2/1/15	2/1/15	10/1/15
42	Woods		Ashlie	prn	6/11/12	RN	7/1/14	7/1/14	7/1/14
43	Young	M	Lynne	1	6/26/06	RN	11/1/15	7/1/15	5/1/15
	530080-Endo								
44	Black	L	Ellen	0.8	1/1/89	10/1/06 CST	10/1/15	n/a	n/a
45	Fase	J	April	1	9/30/13	RN	7/1/14	8/1/15	n/a
46	Ogden	E	Katrina	1	8/19/13	RN	11/1/15	10/1/15	n/a
47	Poff	M	Evelyn	1	5/13/14	RN	5/1/16		n/a
48	Puckett	M	Tammy	1	5/2002	RN	11/1/15	4/1/16	2/1/15

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 9/16/10

NPP#: ORSPP: S-05
Page 1 of 1
EFFECTIVE: 6/12/14

TITLE: STAFFING

Performed by: Team Leader or Designee

Purpose: To provide guidelines for staffing in Surgical Services

General Information: None

Policy Statements:
1. A Registered Nurse will be assigned to perform circulating duties in each Operating Room.
2. A Registered Nurse, Surgical Technologist, Certified Surgical Tech, Student Surgical Technologist (SST), CSTFA or a trained Student Extern will be assigned to scrubbing duties as appropriate.
3. The demands of each room schedule will be optimally matched with skills and expertise of assigned staff.
4. Assignment of additional personnel per procedure will be provided, with consideration to:
    a. Acuity/complexity of procedure (eg trauma, total joint replacement).
    b. Physician request (eg scrub assistant).
    c. Special equipment (eg laser).
5. One CHI competency verified laser nurse will be assigned to each laser procedure.
6. Department Coverage
    a. CHE: Department coverage consists of in house RN staffing 0700-2300 Monday-Friday and 0700-1900 on Saturday and Sunday - - with the exception of holiday coverage. CHE Monday – Sunday, 1900 – 0700, weekends and holidays will be covered by a designated on-call team consisting of at least one RN.
    b. CHN: Department coverage consists of in house RN staffing 24 hours a day. Holiday call is covered by a designated on-call team consisting of at least one RN.
    c. CHS: Department coverage consists of in house RN staffing 0700-1830 Monday-Friday. Weekday nights (1830-0700), weekends, and holidays are covered by a designated on-call team consisting of at least one RN.
    d. CHVH: Department coverage consists of in house RN staffing 0630-1700 Monday-Friday. Outside of timeframe is an on-call team.

Equipment: None

Procedure: None

Documentation Guidelines: None

References: None

Approved by:	Perioperative NPP Subcommittee	Date: 5/2014
	Infection Prevention	Date: 5/14/2014
	Risk Management	Date: 5/14/2014
	CHVH	Date: 5/14/2014
Approved:	NPP Steering Committee	Date: 5/14/2014

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Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 3/25/08

NPP: ORSPP: S-02

EFFECTIVE: 6/13/14

TITLE: SCHEDULING GUIDELINES FOR SURGICAL PROCEDURES

Performed by: RN, LPN, Patient Data Coordinator

Purpose: To provide guidelines for scheduling elective and emergency surgical procedures.

Policy Statements:

1. The administration of Surgical Services is a cooperative effort between the Surgical Services Leadership and the respective Medical Directors.
2. The Director or designee (Clinical Director, Team Leader) is responsible for the provision of nursing and ancillary personnel, as well as appropriate functioning physical facilities.
3. The Medical Director of Surgical Services is responsible for matters involving the physicians utilizing Surgical Services.
4. Inpatient surgical procedures on patients under 14 years of age necessitating admission to the ICU will be done only under emergency circumstances. These surgeries will require a collaborative effort of Surgical Services Leadership, Pediatrics, and ICU (or their designee) and any associated Medical Director(s).
5. All surgical cases scheduled will be done in accordance with infection prevention policies and AORN Recommended Practices.

Definitions

6. **Add On/Urgent Procedure**: Surgery cases added to the current or next day's surgery schedule after the official schedule has been closed or published. These procedures are not immediately life-threatening but are expedited and worked into the schedule as soon as possible.
7. **Block Scheduling**: A system of reserving specific routine periods of operating room time for individual and/or group practice based upon a defined pattern of utilization.
8. **Elective Procedures**: Surgical cases scheduled in advance into assigned block or open time available for surgeons without assigned block time
9. **Emergent Procedure**: A life/limb threatening condition that requires immediate surgical intervention. An emergency goes into the first available room and may require bumping the start of another surgery or rearranging the prescheduled cases. If bumping another case is necessary, it is the surgeon's responsibility to notify the surgeon whose scheduled case is affected.
10. **First Case On Time Start**: Applies to first case in every room with a start time before 9 AM.
11. **Open Time Scheduling**: Periods of operating room time unreserved and available for scheduling on a first come first serve basis. Surgeons without block time have priority for scheduling in unreserved time.
12. **Release Time**: Automatic release time for unused block time converting to open time. Occurs automatically 5 days prior to actual date if no elective cases are scheduled.
13. **Scheduled Start Time**: The scheduled start time is defined as "the patient in the room time."
14. **Turnover Time**: The time the patient leaves the room until the time the next patient enters the room. This includes the clean-up and set up time during this time frame.

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 3/25/08

NPP: ORSPP: S-02

EFFECTIVE: 6/13/14

General Information:

1. The OR Services consists of:
   A. CHE
      1. Five (5) operating rooms, two (2) endoscopy rooms and one (1) pain management room.
      2. All types of surgical procedures may be performed with the exception of organ transplants, and procedures requiring cardiopulmonary bypass.
      3. These specialties should be scheduled in designated rooms to facilitate access to supplies and equipment:

Neurosurgery	OR# 12, 14
Urology	OR# 4
Peripheral vascular	OR #4, 7, 12, 14
Orthopedics	OR# 10, 12
Total Joints	OR# 10, 12
Thoracic	OR# 12, 14
Endoscopy	OR # 8, 9
Pain Management	OR #1

General and gynecology surgeries may be scheduled in any available room.

   B. CHN
      1. Eight (8) general, multipurpose rooms.
      2. All types of surgical procedures may be performed with the exceptions of organ transplants and procedures requiring cardiopulmonary bypass.
      3. NICU surgical patients are a collaborative effort among the Neonatal Nurse Practitioner, the Medical Director of the NICU, Surgical Services Leadership, and the Medical Director of Anesthesiology.

   C. CHS
      1. Six (6) general, multipurpose surgical suites.
      2. Surgical procedures may be performed with the exception of organ transplants and procedures requiring cardiopulmonary bypass.

   D. CHVH
      1. Four (4) general, multipurpose operating rooms. Three (3) rooms are available for scheduling and are staffed Monday through Friday from 0715-1700.
      2. There is one (1) hybrid operating room. When the hybrid OR is utilized and staffed with OR personnel, then there will only be two (2) general rooms available.

2. Availability of time on the OR schedule is determined by:
   A. Type of anesthesia required.
   B. Nursing personnel availability.
   C. Supply and equipment availability (eg, laser, x-ray).
   D. Length of time needed for procedure, including set-up time, operating time and clean up time.

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3. Information to be requested when scheduling includes, but is not limited to:
   A. Date and time requested, surgeon's name, type of anesthesia, procedure to be performed, patient's name, phone number, and date of birth, patient's status (inpatient, outpatient, a.m. admit, 23 Hour Observation), length of time needed, equipment needed.

4. Cancellation
   A. The surgeon informs the CHE office ; CHN or , CHS central desk or scheduling office and CHVH
   B. Should a patient fail to report at the pre-determined time, the surgeon is notified.
   C. Cancellations may be made by the surgeon and/or anesthesia after the patient has arrived if a patient fails to have completed pre-surgery requirements (lab work, consent, registration, etc.)
   D. The OR Team Leader or Clinical Manager or designee in conjunction with the Medical Director of Surgical Services may adjust the day's schedule to facilitate the day.
   E. If there is a cancellation or change in schedule:
      i. Scheduled cases will be offered earlier times first at the discretion of the Medical Director and/or charge nurse or designee,
      ii. Add-on cases will be considered next

Procedure:

1. Elective Surgery
   A. CHE
      1. The scheduling office is open between the hours of 0800-1700 M-F. Scheduling may be accomplished via telephone ( ). Requests may be called to the OR Department when the office is closed.
         a. Monday-Friday 6:30am to 7 pm. Saturday and Sunday 7am-7pm with call coverage all other times and holiday. The OR is staffed 24 hours a day, 7 days a week, except holidays.
      2. Procedures scheduled via phone, or in person should include the information in "General Information 4".
      3. Requests are accepted only from the physician or personnel employed by the physician.
      4. The operating rooms are routinely be utilized for elective scheduling Monday-Friday, between the hours of 0700-1800.
         a. One (1) room may begin at 0700 am or 0730 am if deemed necessary by the Team Leader and/or Medical Director.
         b. Three (3) rooms will be staffed until 1530, two (2) rooms will be staffed until 1730 pending staffing needs.
      5. The elective schedule for the next day closes at 1700 on the day prior. All procedures for the next day that are scheduled after this time, are considered add-ons and should be scheduled through the OR Team Leader or designee.
      6. An open scheduling system is used. Room assignments are on a first come, first served basis. Every effort is made to ensure that the same surgeon follows himself/herself.

7. Only emergent procedures are performed on Thanksgiving, Christmas, New Year's Day, Memorial Day, July 4th and Labor Day. Friday after Thanksgiving, one room covered by on-call. Medical Director opens a second room if deemed necessary.

B. CHN
1. The scheduling office is open between the hours of 0700 to 1630, Monday-Friday. Scheduling may be accomplished by telephone or in person.
   a. Inpatients, a.m. admissions, and observations are to have a bed reservation.
   b. Only emergencies and urgent cases are done after the scheduled OR hours.
   c. The OR is staffed 24 hours a day, 7 days a week, except holidays. Holidays are covered by a designated On-Call Team.
2. Procedures scheduled via phone or in person should include the information in "General Information CHN 4".
3. Requests are accepted only from the physician or personnel employed by the physician.
4. The elective schedule for the next day closes at 1630 on the day prior. All procedures for the next day that are scheduled after this time are considered add-ons.
   a. On weekends and holidays, requests for scheduling on the next business day are accepted by calling surgery at
   b. If the department has staff on duty, the surgeon may call and give all information to the staff person on duty who passes the request on to the Clinical Manager/Team Leader/Designee on the next business day. A return call the following business morning confirms the receipt and disposition of these requests.
5. Block scheduling guidelines.
   a. There is a combination of block and open scheduling.
   b. There is a combination of block and open scheduling time.
   c. Block time owners may not allocate their block time to another surgeon.
   d. CHN/CHE/CHS-Block is released 168 hours (7 days) prior to scheduled block time if the time is not utilized.
   e. CHVH-Block time is released 120 hours (5 business days) prior to scheduled block time if the time is not utilized.
   f. Quarterly evaluation of block time is performed by Surgical Services leadership and the Medical Director. Adjustments can be made after consultation with the surgeon according to the percentage of block time utilized.
   g. CHVH-To maintain block time, utilization must be at least 75% as measured on a quarterly basis. A calculation of turnover time is included towards block time utilization.
      i. Block time owners are made aware of utilization on a quarterly basis. If at the end of a quarter, utilization is below 75%, the owner has the next quarter to improve utilization to 75%. If 75% is not met, adjustments to decrease the block time are made.
      ii. Prior to adjustments of decreasing time, outside factors are taken into consideration (ie. surgeon in front of you consistently runs over into your block time thereby preventing you from reaching 75% utilization).

iii. Utilization above 75% is evaluated on a quarterly basis to determine if an increase in time is needed.
iv. Time utilized outside of assigned block time is not be allocated toward block time utilization.
v. Block Utilization % = hours used inside the block + allowed turnover time (less approved released time)
block hours allocated (less approved released time)

h. If a surgeon has block time that covers the first case of the day, first case on time starts will be monitored and will play a role in maintaining block time.
i. Surgeons are required to be in the hospital 15 minutes prior to in-room time and should notify the OR by calling 1-8950 if they are running late.
j. If a surgeon has three late starts in one quarter related to not being present 15 minutes prior to in room time, the surgeon will have the next quarter to correct his first case on time starts prior to block time being adjusted.
k. Outside of emergency and urgent add-ons, surgeons with block time must schedule and fill this time prior to being allowed to schedule in open time. Surgeons without block time are given priority in open time.
l. The Hybrid OR will be blocked for TAVRs and CTOs based upon necessity to do procedure. Block time is released one week prior. The Hybrid OR is blocked from 0800-1300 for vascular surgeon's on their normal block days outside of block time allocated for TAVRs and CTOs.
m. It is the responsibility of the block time owner to manage and release block time appropriately to ensure adequate utilization. It is the surgeon's responsibility to notify the OR scheduling office at least two weeks in advance when block time is not needed related to vacation or time off. Block time releases made two weeks prior to the surgery made are not counted against block time utilization.

6. The elective schedule is closed or reduced on:

EMERGENCY ONLY:
Thanksgiving
Christmas
New Year's Day
July 4th
Labor Day

FOUR (4) ROOMS ONLY:
Friday after Thanksgiving

C. CHS

1. Operating Rooms are available for scheduled elective procedures Monday-Friday 0800-1730.
   a. Inpatients, a.m. admissions, and observations must have a bed reservation.
   b. Cases may be scheduled beginning at 0800. A maximum of two 0700 cases may be scheduled with consideration given to preparation time and staffing availability.
   c. One room is scheduled until 1530, one room is scheduled until 1730. If there is a need for an additional room until 1730, it is at the discretion of the Team Leader or designee.
   d. Call the Surgery Desk (or add-ons to the surgery schedule.

e. Only emergencies are done after the scheduled operating hours.

2. Authorized personnel enter scheduling requests into the computer.
   a. Surgery scheduling is open Monday-Friday 0800 a
   b. Elective procedures should be scheduled by 1700 the day preceding surgery.
   c. Requests are accepted only from the physician or personnel employed by the physician.
   d. Weekdays and holidays -requests for scheduling on the day following are accepted by the call coordinator.
      1) Reservations are subject to all regular criteria.
      2) Confirmation and/or denial of request are communicated to the physician on the morning of surgery.
3. Block scheduling guidelines
   a. Type of scheduling is a combination of block and open.
   b. Block requests are considered on the basis of utilization. Specialty blocks are given based on the percentage of total procedures.
   c. Release of the block 48 hours to 7 days (exception: due to having one da Vinci robot, block time in that room are released two weeks from the day of the procedure). Release of block time is negotiated with the physician and is based on the percentage of utilization.
   d. Block utilization is evaluated and discussed with physician.
   e. Adjustments in blocks may be necessary if utilization percentage is below 60% or above 85%.

D. CHVH
1. With the exception of the holidays, the OR is staffed ten (10) hours a day, five (5) days a week. After hours and emergency cases are staffed with on-call staff as needed. Holidays are covered by a designated on-call team. Recognized holidays include:

New Year's Day	Memorial Day
Fourth of July	Labor Day
Thanksgiving	Christmas

   A reduction in available ORs for scheduling may occur New Year's Eve, the day after Thanksgiving, Christmas Eve, the week between Christmas and New Years and the week of spring break(s).
2. Cases may be scheduled Monday through Friday between 0800-1700. Scheduling requests outside of these times is determined on a case by case basis. Only emergencies and urgent cases are done after the scheduled OR hours.
3. Surgery schedules are closed/published Monday through Friday at 1630. Any request outside of this time is treated as an add-on.
4. Availability of time on the OR schedule is determined by:
   a. Type of anesthesia required
   b. Availability of nursing staff
   c. Availability of supplies and equipment (ie: TEE, laser, x-ray)
   d. Length of time needed for procedure, including set-up time, operating time and clean up time.

5. To schedule a case call the **Scheduling Office at** between 0700 and 1700. After these hours the scheduling line is forwarded to the House Supervisor to handle requests for add on/urgent or emergent procedures.
6. Scheduling requests may also be submitted via fax at
7. All requested information must be provided to the surgery scheduler prior to the surgery being placed on the schedule. Information necessary to put a case on the schedule includes, but is not limited to:
    b. Date and time requested
    c. Surgeon's name
    d. Type of anesthesia
    e. Procedure to be performed
    f. Patient's name, phone number, and date of birth, and social security number
    g. Length of time needed
    i. We reserve the right to alter surgeon requested time based on historical case data.
    h. Special supplies or equipment needed
    i. Patient status
    i. Inpatients, AM admissions, and outpatients must have a bed reservation
    ii. Patients cannot be placed on the schedule in an 'observation' status. CMS dictates that an observation status may only be deemed necessary after the procedure has occurred and the patient's status at that time warrants observation.
    iii. The patient status of a Medicare patient is governed by Medicare's Inpatient Only List. When scheduling Medicare patients as an outpatient, be prepared to share the predicted CPT code. Scheduling personnel will check this CPT code against the Inpatient Only List. If the CPT code is on this list, the patient must be scheduled and treated as an inpatient.

2. Surgery Waiting List (CHE & CHN)
    A. When a surgeon calls to schedule a case and there is no time available, the scheduling coordinator:
        1. Attempts to open another room subject to:
            a. Equipment/supplies needed.
            b. OR staff availability.
            c. Anesthesia availability.
        2. Offers to place the physician/procedure on a waiting list.
    B. If there is a cancellation or change in schedule:
        1. Scheduled cases are offered earlier times first at the discretion of the Medical Director and/or Team Leader or designee.
        2. Then the first surgeon on the waiting list is called and offered the time. If he declines, he is bypassed and the next surgeon is called.

3. Scheduling add-ons are on a first come, first serve basis.
    A. Anticipated start times are identified when the procedure is scheduled.
    B. Surgeons are to be notified as soon as possible if the start time may be delayed.

C. Should a surgeon be unable to move up when requested, that time may be filled with another procedure of similar length.
D. No substitution of patient names or unrelated procedure is accepted.
E. The above referenced patient information is required at the time of scheduling from the physician or the physician's office. The surgery may not be scheduled with only a patient name.

4. Urgent/Add-On and Emergency Surgery, Regular Working Hours
   A. Urgent/add-on and emergency procedures are accommodated on a first come, first serve basis subject to the nature of the patient's condition.
   B. The surgeon notifies CHE Surgery CHN CHS
      a. Patient procedure information is recorded, and includes those items mentioned above.
   C. The secretary, Team Leader, Clinical Director, or designee:
      a. Notifies the anesthesiologist and rearrange the schedule as needed.
      b. Contacts the surgeon to confirm surgery start time.
      c. Notifies POCU to change pre-op medication times or to delay sending for a scheduled patient.

5. Emergency Surgery, Non-working Hours
   A. CHE has staff cover phone calls 7 days a week, 24 hours a day.
      a. The Emergency Department, or the surgeon, calls the main OR at schedule the procedure.

   B. CHN
      a. CHN OR has in-house staff 24 hours a day, 7 days a week. Exception: Holidays are covered by a designated On-Call Team. There is always available a total of two (2) OR people on weeknights and three (3) OR people on weekends and holidays if needed.
         1.) The surgeon calls to speak with a staff person to schedule the procedure.
         2.) The staff person calls/pages the "1st call" anesthesiologist.
         3.) When the "1st call" anesthesiologist returns the call, the CHN OR staff person relays the case information to the anesthesiologist. The anesthesiologist confirms the start time.
         4.) The staff person returns the call to the surgeon to verify the start time.
         5.) The staff person notifies the "on call" team of the emergency/urgent case.
         6.) If necessary, the first on-call staff person arriving for duty obtains the OR keys.

   C. CHS
      A. During non-working hours, emergency surgery is staffed by a designated on-call team. The hospital operator has the on call roster.
      B. The surgeon notifies the call coordinator that he/she has an emergency to schedule.
      C. The call coordinator:
         a. Requests the patient/procedure information.
         b. Notifies the on-call anesthesiologist and surgery team.

   D. CHVH

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After Hours (after 5 pm Monday – Friday) and Holidays

a. The surgeon calls 621-8950 and speaks with the on-call coordinator to schedule the procedure
b. The anesthesiologist on-call is contacted by the on-call coordinator with case information, which includes the estimated/requested start time.
c. The on-call coordinator then alerts the House Supervisor to contact the "on-call" team of the emergency case.

Weekends

a. Weekends are reserved for the scheduling of urgent/emergent cases.
b. Every effort should be made to do cases M – F.

6. Advance Notification of emergency surgical procedures to be performed on Saturday, Sunday or holidays.

A. CHE has staff cover phone calls 7 days a week 24 hours a day. Therefore, staff is made aware of the scheduled procedures.

B. CHN

1. Surgical procedures that are to be performed may be scheduled beginning at 0700 24 hours prior to the weekend/holiday.
2. Calling reaches an OR staff person as this number is forwarded to the charge nurse phone after the scheduler is off duty.
4. All necessary staff are made aware of the case so it can start on time.

C. CHS

1. Surgical procedures that are to be performed on Saturday, Sunday or holidays are scheduled beginning at 0800 24 hours prior to the day of surgery.
   a. An anticipated start time may be given subject to earlier requests, emergencies and/or anesthesia availability.
2. Friday- 0800-1700 the scheduling service accepts requests at weekend cases. After 1700, call the surgery department at schedule a procedure. The OR call coordinator can be reached by calling the hospital operator if staff have completed their shifts and are gone for the day.
3. If the OR and PACU on-call are aware of the procedures, the call coordinator does not call the team unless there has been a change.

CHVH

Management of the Daily Schedule

1. It is a team effort to start surgery on time and all participants of the OR team (including physicians) are held accountable to ensure timely starts.
   a. Anesthesia assesses the patient no later than 15 minutes prior to in room time.
   b. Peripheral vascular surgeons are present 15 minutes prior to in room time.
   c. Cardiovascular surgeons are present 15 minutes prior to in room time.

d. OR staff are to have surgical patients in the room no later than five (5) minutes of scheduled in room time.

2. Except in emergency situations, patients are not transferred to the OR until all team members are present and required documentation is complete. Required documentation consists of:
   a. Complete history and physical that has been appropriately updated the day of surgery.
   b. Signed surgery and anesthesia consents
   c. Signature indicating Informed Consent by the physician
   d. Completion of surgical site marking if appropriate

   If a physician consistently fails to meet requirements, it could result in penalties such as loss of Block Time, inability to schedule, etc.
3. In the event of delays, the operating room staff proactively notify surgeon by placing calls or paging to communicate as soon as possible. An indication of the estimated length of time before the procedure can begin is given.
4. The charge nurse and the anesthesiologist in charge will collaboratively be responsible for adjusting time frames due to cancellations, delays or any unexpected time openings. Elective cases have priority for completion over add on cases, however, facilitating the completion of the schedule in a timely efficient manner is taken into consideration.

Documentation Guidelines: None

References: None

Approved by:	Perioperative NPP Subcommittee	Date: 6/2014
	Clinical Director Surgical Services, CHE	Date: 6/2014
	Clinical Director Surgical Services, CHS	Date: 6/2014
	Clinical Director Surgical Services, CHN	Date: 6/2014
	Director, CVOR	Date: 6/2014
	Medical Director, Anesthesia, CHE	Date: 6/2014
	Medical Director, Anesthesia, CHS	Date: 6/2014
	Medical Director, Anesthesia, CHN	Date: 6/2014
	Medical Director, Anesthesia CHVH	
	Risk Management	Date: 6/2014
	Infection Prevention	Date: 6/2014
Approved:	NPP Steering Committee	Date: 6/11/2014

UNIT PROTOCOL

TITLE: CALL GUIDELINES

The call guidelines for CHS Surgery Department are subject to change as deemed necessary by the Team Leader and Surgery Coordinator to cover any unusual circumstances (i.e. MLOA, resignations, new hires, etc.)

CALL RESPONSIBILTIES

1. It is each employee's responsibility to be available for their assigned call at the end of their shift. On an employee's day off, call hours begin at 1530. Failure to be available when on call is to be documented on an incident report and to be reported to the Team Leader for further action.

2. It is each employee's responsibility to notify the Call Coordinator of where and how he/she can be reached if he/she is not at home. Also, it is the responsibility of the employee to make sure that his/her pager is on and in working order.

3. Each call crew should consist of an anesthesiologist, pre-op/recovery nurse, a circulator and a scrub. The circulator must be an RN. Most cases will require two scrubs. This decision is at the discretion of the Call Coordinator.

4. Tech's and RN's will both be assigned call.

5. On call personnel need to be able to reach the hospital within 30 minutes during on call hours.

6. In the event of an IOPO case, the Call Coordinator will be required to come in. Call one and Call two employees are only required to come in if IOPO is doing a live harvest and will need an anesthesiologist.

7. In the event of an endoscopy case, only one registered nurse should come in to assist anesthesia, as both the endoscopy call nurses will be

8. there. (ie: If Call One is a CST, and Call Two is an RN, Call Two will be required to come in. If Call One and Two are CST's, then the Call Coordinator will be required to come in).

CALL COMPENSATION

1. Stipend pay is $5 per hour. Stipend pay remains in effect even during the call hours that are being worked.

2. The current pay rate if you are called in is time and one half your hourly rate.

3. Each employee is allowed one four-hour minimum per shift (Shifts are as follows 0700-1500, 1500-2300, and 2300-0700). You are guaranteed 4 hours of pay at time and one half your hourly rate if you are called in, even if you were here for a shorter period of time. After the four-hour minimum, you are paid time and one half your hourly rate for the hours worked, unless you are called in during a different shift.

4. Employees that share call hours must split the four-hour minimum if relieved during a case. Otherwise, each employee is still eligible for one four-hour minimum per shift, even if the call hours are being shared amongst them.

5. You are eligible for evening and weekend premiums if you are called during those shifts. Holidays are equal to weekend shifts.

6. There is no limit to the amount of call anyone takes after a fair distribution of the available call hours is dispersed. However, should excess call hours interfere with regular duties, and is documented by co-workers and/or management, steps will be taken to correct the situation.

CALL COORDINATOR RESPONSIBILTIES

1. The Call Coordinator will be an approved RN who has shown leadership capabilities within the department.

2. The Call Coordinator will take call for a one-week period of time.

3. The Call Coordinator will be the first contact from the surgeon, ER, anesthesia, or ancillary staff to schedule a procedure.

4. The Call Coordinator will be responsible to call the OR crew as needed in a timely manner.

5. The Call Coordinator will be a resource person for those on duty or on regular call.

6. Stipend pay is the same as regular call, $5.00 per hour.

HOLIDAY CALL

1. Holidays are: Memorial Day, July 4th, Labor Day, Thanksgiving, Christmas Day, and New Year's Day. Easter, Christmas Eve, and New Year's Eve are not paid holidays.

2. Holiday rate is paid on the day our department is off for the holiday. This is not necessarily the same day as the actual holiday.

3. Holidays are signed up for once a year. The Team Leader makes the decision regarding how employees will sign up for holiday call.

4. It is each employee's responsibility to sign up for approximately three holiday call dates/times.

REGULAR CALL ASSIGNMENTS

1. Weekday call is Monday through Thursday. Weekend call is Friday

2. through Sunday. (The weekend stipend starts at 12:01 AM Saturday).

3. Monday through Friday call starts at the end of each employees shift, or at 1530 if it is his/her day off, and call ends at 0700 the following morning. Weekend call starts at 0700 Saturday and/or Sunday, and ends the following morning at 0700.

4. Each employee is off call at 0700 the following morning, and all efforts must be made to relieve him/her. If an employee is able to stay, it is greatly appreciated, yet, it should not be taken for granted.

5. Each employee must sign up for his/her own assigned number of call days. Call will be as evenly distributed as possible by the Team Leader.

6. Each employee will sign up for call according to a rotating roster each schedule.

7. If "extra call" is desired, there will be a box on the schedule that can be checked. "Extra call" will be distributed according to that schedule's sign up rotation.

8. If you do not want to take or are unable to fulfill your assigned call, you should circle your call date(s). Your call will be divided equally amongst the employees wanting "extra call." If for any reason your call is not covered, you are then responsible to take the call.

9. Only the Team Leader or Surgery Coordinator can make approved changes on the call schedule.

NEW EMPLOYEE CALL

1. A new employee can take "buddy call" once the Team Leader, the Surgery Coordinator, and his/her preceptor decides that he/she is ready.

Updated July 22, 2004

2. There is no limit to the amount of "buddy call" that an employee can take, as long as the Team Leader decides it is not detrimental to that employee's learning.

3. There will be mandatory call for new employees for the first 3 months post orientation. This call may be traded, yet, cannot be given away.

4. The new employee should make sure to sign up for call on a night that an experienced employee is on call.

Updated July 22, 2004

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 10/16/08

NPP#: ENDO: C-01
Page 1 of 2
EFFECTIVE: 4/30/13

TITLE: ON CALL GUIDELINES

Performed by: RN, LPN

Purpose: To establish on call guidelines.

Policy Statements:
Physicians needing to perform emergency GI procedures after normal business hours will follow established guidelines for each Endoscopy Department.

General Information: None

Equipment: None

Procedure:
NORTH:
1. Hours of on call nurses: Monday-Friday 1700-0630, and weekends/holidays 0700-0700.
2. One Endoscopy trained RN will be on call at all times.
3. Physicians should contact the hospital operator at , giving them specific information concerning the case (e.g., procedure to be done, equipment needed, type of scope).
   a. The operator will contact the on call nurse listed on the Endoscopy on call schedule. One Endoscopy trained nurse will be called in for surgery, emergency room, and critical care cases. The second person for the procedure will be a registered nurse from the respective unit acting as the monitoring RN.
   b. A second Endoscopy trained nurse will be on call weekends and holidays from 0800 – 1200.
   c. Physicians may call the on call nurses directly if preferred.
4. Emergency procedures will be performed in the Emergency Department, Radiology, Operating Rooms and Intensive Care. Inpatients will be done in the Endoscopy Department on holidays and weekends from 0800 – 1200.
5. Endoscopy staff has 45 minutes travel time. The procedure will begin as soon as possible after that time.

East:
1. On call staff will be available after hours as follows:
   a. Monday through Friday after 1700 – one Endoscopy trained nurse available for emergent cases performed at the bedside in selected areas with the assistance of the bedside RN.
   b. Weekends and hospital designated holidays – one Endoscopy trained nurse 0700 – 0700, with second on call nurse available during 4-hour period 0800-1200 each day. Second on call nurse is available to assist with medical patients who meet the established criteria and can be done in the Endoscopy Department.
2. On call staff can be contacted through the hospital switchboard at Staff will be paged by the operator. Patient and case information must be communicated personally by the physician, to the on call staff member , as this will ensure that staff has all the information needed to prepare for the case.
3. On call staff has 45 minutes' travel time and will begin setting up the cases immediately upon arrival.

South:
1. Hours of "On Call"

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   a. Weekdays: one Endoscopy trained nurse will be on-call at all times depending on where the procedures are done. Call hours begin at the end of the employee's scheduled work hours.
   b. Weekends/Holidays: The Endoscopy Unit will have 24 hour coverage by Endoscopy personnel
2. Emergency procedures performed in the Endoscopy Department and the Emergency Department: the call one Endoscopy nurse will contact a second Endoscopy nurse until 2200; thereafter, the call two PACU nurse will cover call hours from 2200-0700.
3. Emergency procedures performed in the Intensive Care Unit and Progressive Care Unit will be staffed by an on call Endoscopy nurse and the unit nurse assigned to the patient.
4. Notification of Endoscopy On Call personnel.
   a. Physicians should contact the hospital operator after 1700 at The operator will page the on call Endoscopy nurse to call the physician.
   b. Physicians may call the on call Endoscopy nurse directly if preferred.
5. Staff has thirty minutes travel time. They will begin setting up the case immediately upon arrival.
6. As necessary, Endoscopy call staff will be utilized as back-up for PACU.

References: None.

Documentation Guidelines: None.

Approved by:	Infection Control	Date: 3/13
	Risk Management	Date: 3/13
	Endoscopy Subcommittee	Date: 3/13
Approved:	NPP Steering Committee	Date: 3/13/13

QUALITY/SAFETY MANAGEMENT PLAN
SURGICAL SERVICES

Community Hospital South
Community Hospital North
Community Hospital East
Community Hospital Anderson

July 2011

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I. Mission/Vision/Value Statements

Mission

The mission of Surgical Services is to be a leader in providing a full continuum of services to the community services by the Community Health Network. We will be central Indiana's most preferred inpatient and outpatient surgical service provider and we will deliver unsurpassed service to our physicians and their patients. In partnership with our medical staff, we offer innovative and individualized surgery options that are responsive to our customer's needs. We are committed to efficiently and safely delivering the highest quality surgical care, creating an exceptional experience for physicians, patients, families and employees.

Vision

It is the objective of Surgical Services to accomplish our Mission by partnering with physicians, patients, families and employees. We will benchmark performance indicators and major processes. We will creatively develop new approaches and alternative delivery systems offering state of the art technology for best demonstrated practices in surgical services. These continuous improvements will result in a system that will provide high quality services as evidence by total customer satisfaction.

Values

Patients First: We believe that patients' needs, and the needs of their families, are our number one priority.

Relationships: We are inclusive, working together as partners and teams.

Integrity: We expect truth-telling and transparency.

Innovation: We foster creativity and openness to new ideas.

Dedication: We are accountable stewards of the resources entrusted to us.

Excellence: We provide access to a high quality and safe environment of care, known for high performance.

Community's statement of values is all about making our organization the best it can be—providing the most exceptional experiences possible for patients and families, opening our doors to all who desire our services, building the health care workplace of choice for central Indiana, creating exceptional experiences for physicians, ensuring that our organization is

efficient and fiscally healthy. We can't succeed as a team unless we all live our values, which we remember with the acronym PRIIDE.

Business Growth

We strive to continually grow our business by creating the most surgeon-oriented surgical facilities in the Midwest. We provide our patients with the strongest blend of quality, service and price, making our facilities the customer's and payer's choice for surgical care.

Financial Performance

We focus on the delivering safe and cost-effective health care through efficient use of our resources.

II. Types and ages of patients served

Surgical Services provide services tailored to the special needs based on age: newborns (CHN), infants, children, adolescents, adults, and senior adults. Interventions are provided throughout the continuum with the exception of major organ transplantation.

III. Scope and complexity of need; extent to which needs are met

Services are designed for all levels across the health continuum. Services include education and consultation from pre-procedure planning to discharge follow-up.

The continuum of care is comprehensive and includes but not limited to:

- Community Support
- Consultation
- Education
- Home Health
- Inpatient
- Outpatient
- Pre-Operative Clinic
- Wellness

Unit Description

CHE	6	Surgery Suites
	2	Procedure Suites
	6	PACU surgical beds (to include one isolation bed)
	6	Pre/Post-operative beds
	3	Endo beds
	1	Pre-op Clinic bed
CHN	8	Operating rooms approximately 650 square feet each
	9	Minor procedural care unit with 9 procedure rooms: ECTs

	15	Private pre-operative rooms (2 of which can function as PACU bays if necessary)
	6	Dedicated PACU bays (total of 8 if utilizing 2 pre-op rooms noted above)
	2	2 of the above 23 rooms able to care for isolation patients
	1	Assisted fertility laboratory
		Post-operative care beds
CHS	6	Surgery suites
	9	PACU I beds (to include one isolation bed)
	17	Pre/post beds (includes 1 isolation bed)
CHA	6	Surgery Suites
	9	Special procedures suites
	1	Mobile lithotripsy unit
	1	OB C-Section suite
	18	Pre/post-op beds (includes 1 isolation bed) (* also called extended recovery or PACU II)
	6	Pre/post-op lounge chairs
	8	PACU I surgical beds

Surgical inpatient units (pre/post procedure care)

Each patient's need for nursing is assessed by a Registered Nurse at the time of admission with a complete health assessment including physical, psychological, self-care, educational and environmental factors relating to discharge planning per policy. When necessary and appropriate, data is obtained from the patient's significant other and/or family and is included in the assessment. Aspects of data collection may be delegated by the RN to a Licenses Practical Nurse, Clinical Technician, Patient Support Partner, or a Student Nurse Extern. Reassessment of the patient's condition occurs at least every eight hours by an RN or more frequently based on changes in the patient's condition.

A care manager is designated on admission and is accountable for planning the care throughout the hospital stay using patient care pathways and multi-disciplinary team members such as Clinical Nurse Specialists, Social Services, Utilization Review/Case Managers and Physicians. The plan of care is made with input from the patient and/or significant other to provide quality patient focused care. Patient/families education is completed based on assessed needs and reinforced prior to discharge. How well we meet patient's needs and expectations is measured through patient satisfaction surveys and appropriate referrals made as necessary.

Observation Unit

This unit provides care for post surgical/procedural patients as well as medical patients.

Each patient's need for nursing care is assessed by an RN at the time of admission with a complete health assessment including physical, psychosocial, self-care, educational and environmental factors relating to discharge planning per policy. When necessary and appropriate, data is obtained from the patient's significant other and/or family and is included in the assessment. Aspects of data collection may be delegated by the RN to an LPN, Clinical Technician, or a Student Nurse Extern. Reassessment of the patient's condition occurs at leader every eight hours by an RN or more frequently based on changes in the patient's condition.

The RN is accountable for planning the care throughout the observation stay using patient care pathways and multi-disciplinary team members such as Clinical Nurse Specialists, Social Services, Utilization Review/Case Managers and Physicians. The plan of care is made with input from the patient and/or significant other to provide quality patient focused care. Patient/families education is completed based on assessed needs and reinforced prior to discharge. How well we meet patient's needs and expectations is measured through patient satisfaction surveys and appropriate referrals made as necessary.

Pre-op Clinic

The pre-operative clinic offers pre-admission testing/screening and education for patients 2-3 weeks prior to their surgical procedure. Patients can be seen by an anesthesiologist or internal medicine physician via surgical referral. Patient seen by an anesthesiologist is based on ASA rating; ASA 3-4 are automatically seen by an anesthesiologist. One hour clinic appointments can be made through Centralized Scheduling at and can be scheduled from 8:00 a.m. – 3:30 p.m. Monday through Friday, according to needs of specific sites. Internal medicine clinics are scheduled from 12:00 p.m. – 5:00 p.m. Monday, Tuesday, Wednesday at CHS. These appointments can be made via Centralized Scheduling or by calling a clinic nurse at Pre-op clinics at CHE can be scheduled from 9:00 a.m. – 2:00 p.m. Monday and Wednesday. Same day appointments at CHN may be made at 317-621-5152. Special arrangements may be made outside of this time if needed.

Surgery pre-procedure area

The RN receives and admits the patient to the unit. The patient is initially identified using at least two patient identifiers. The RN performs and assessment on each patient who is admitted through this unit. This assessment includes the identification of the patient's physician, psychosocial, spiritual and economic needs. The RN also obtains a complete health history by utilizing advanced interview techniques, including open-ended questions to gather data. Labs, x-rays, EKG and other tests are ordered based on direction from the Surgeon, Endoscopist and/or Anesthesiologist/physician. All verbal and/or telephone orders are verified by the RN utilizing the RAV read-back and verify) system. Pre-procedure teaching is done by the RN with the patient, and/or family/significant other. The site verification process with the surgeon is initiated here with involvement of the patient and family or significant other. This educational component includes, but is not limited to, the process that is utilized to ensure the patient's safety, such as repetitive questioning regarding allergies, type of procedure, and patient cart rails in place. The patient is apprised of what

can be expected from the Anesthesiologist/physician such as meeting him/her pre-procedure, having an IV started (if not already in place), and the process of anesthesia sedation. The patient is also educated regarding the stay in the PACU if appropriate. The RN discusses the discharge instruction sheet and reinforces those areas that are specific to the patient and his/her procedure. Although there is a basic teaching plan in place, education is individualized to address those previously assessed needs. The patient acknowledges problems that are identified and addressed by the RN pre-procedure. These potential problems include but are not limited to the need for crutches or walker, lack of a ride home, or lack of a responsible person to stay with the patient at home.

Pre-procedure medications are administered and IV fluids are initiated by the RN/LPN as ordered by the Anesthesiologist and/or Surgeon. The RN/LPN ensures that consent for the procedure has been obtained prior to administering pre-operative medication to the patient. Any relevant information regarding a patient's special needs is communicated verbally to the Operating Room RN and PACU RN utilizing the "hand-off" approach in addition to documentation of the same.

A systems approach is utilized when the RN performs the assessment of a patient prior to a procedure. Baseline vital signs, including temperature, pulse, respiration, pulse oximetry, and blood pressure measurement are obtained. Cardiac monitoring is available as necessary. A re-assessment is performed as deemed necessary by the RN based on subjective and objective data. An RN is always in attendance/available when a patient is present in the unit.

Surgery

All patients undergoing a surgical procedure are assigned a minimum of one circulating registered nurse and one scrubbing registered nurse or certified/surgical technician. Additional circulators and scrubs are provided based upon the acuity/complexity of the procedure, physician request, and/or use of special equipment such as a laser. The site verification process continues with the "time-out" taking place with the entire surgical team involved by active communication. AORN Recommended Standards will be utilized as guidelines for safe optimal staffing and practice within the operating room setting. A Board Certified or Board Eligible Anesthesiologist provides all anesthetics within the surgery setting. All sites provide 24-hour staffing coverage. At CHS staff are on-site staff from 7:00 a.m. – 6:30 p.m. Monday through Friday. At CHE staff are on-site from 7:00 a.m – 7:30 p.m. Monday through Friday. At CHN staff are on-site 24-hours a day, 7 days a week. Exact times for scheduled procedures vary slightly by site. Add-on cases are performed on a case-by-case basis based upon the current surgery schedule at the time of request. After hours and emergency services are provided by on-call teams.

PACU I

Our Handoff Communication Process is continued at this time. The PACU RN receives a verbal report from the Anesthesiologist and Circulator as she/he accepts responsibilities for the patient's care. The RN performs an initial assessment and documents the findings. The assessment includes, but is not limited to, patency of airway, respiratory rate and depth,

blood pressure readings, condition and color of skin, patient safety needs, neuromuscular status, presence and condition or drainage tubes and catheters, dressing on operative sites, location and condition of IV sites and lines, assessment and documentation of input and output, Aldretti type score, and level of emotional and physical support needed. This assessment is ongoing during the patient's PACU care. The RN re-assesses the patient every 15 minutes during PACU care, but may perform a re-assessment more frequently if condition warrants. All RNs delivering care are ACLS certified. At CHN all RNs are required to be PALS certified due to the pediatric population.

A certain level of competence is required by all RNs delivering this care, therefore each is deemed competent to care for a patient of any acuity/complexity. Although assignments of patients are based on ASPAN standards for patient's classification, each patient receives care on the basis of assessment of needs.

Re-assessments are performed with any changes in condition, cardiac rhythm and post-invasive procedure. The data obtained is interpreted and documented by the RN. Nursing actions and/or interventions with outcomes are documented. The RN collaborates with the Anesthesiologist and/or Surgeon as appropriate. All orders are read-back and verified with the ordering physician.

The same standard of post-anesthesia care is provided to ICU patients whether in the PACU or in the ICU, based on Anesthesiologist's orders. The care is provided by ICU RNs who have been cross-trained. At CHA patients who return to ICU from the OR are recovered by the PACU RN for the first hour.

When a patient has met discharge criteria, but their bed is unavailable, re-assessments and vital signs will be completed every thirty minutes.

Those patients whose total care requires expertise and resources that are unavailable at CHI will be stabilized, treated, and transferred to the appropriate facilities.

Post-Op/Phase II

This area is a step-down unit from the Phase I unit. Patients are taken to this unit to recover prior to discharge. Patients who have received only local or IV sedation are generally taken here directly from the procedure room. At CHN and CHS Phase I and Phase II levels of care and not separate areas, the care to the patient is provided in the same room. There is no physical movement of the patient between levels of care. Families are able to join the patients during Phase II level of care. Discharge instructions are reinforced with patient and family by the RN and a written and/or electronic copy is sent home with patient.

A complete assessment utilizing a systems approach is performed by the RN on each patient upon admission to PACU II and prior to discharge utilizing the hand off communication again. Re-assessments are done as necessary with any change in condition or previously assessed parameters. Cardiac monitoring and pulse oximetry capabilities are available if necessary. If a patient's condition warrants, he/she will be transferred to PACU I.

Home Care

- Involved with continuum of pathway
- Referred to appropriate home care specialist
- Involve hospital Social Services as necessary
- Special needs are met by referral to specialty personnel, i.e. ostomy care, education, and physical therapy for crutch and/or walker training.

IV. Appropriateness, clinical necessity and timeliness of support services provided directly by the organization or through referral contacts

Surgical services are provided by a multi-disciplinary professional staff which includes but not limited to: Primary Care Physicians, Surgeons, Anesthesiologists, Physician Assistants, Nurses, Certified Surgical Technologists and internal and external Case Managers. Ancillary Surgical Services staff includes: Student Nurse Externs, Clinical Technicians, Certified Surgical Technologist Students and volunteers. In addition, clinical support is provided by: Respiratory Care, Pharmacy, Radiology, Laboratory, Nutrition, Physical Therapy, Social and General Services, Materials Management, Finance and Information Systems as needed in a timely manner.

The administrative staff for Surgical Services includes: the Executive Director, Medical Directors, Team Leaders, Clinical Directors, a Financial Consultant and a Human Resource representative.

V. Availability of necessary staff

Surgical Inpatient Unit (pre and post operative care)

Care delivery is provided by using a Care Team Model and the master staffing plan. Assignments are based on the following elements:

- Continuity of nursing staff assigned
- Complexity of patient condition
- Dynamics of patient acuity level
- Type of technology required to provide nursing care
- Competency level and degree of supervision required by staff
- Availability of supervision in relation to the assessed and current competency level of staff.
- Consideration of relevant Infection Control and Safety issues.

To ensure availability of adequate staff the following mechanisms are in place:

- Twenty four hour leadership accountability
- Centralized Scheduling (Pre-Op Clinic)
- Human Resources
- Network Float policies

Observation Unit

Care delivery is provided using the master staffing plan. Assignments are based on the following elements:

- Complexity of patient condition
- Dynamics of patient acuity level
- Type of technology required to provide nursing care
- Competency level and degree of supervision required by staff
- Availability of supervision in relation to the assessed and current competency level of staff
- Consideration of relevant Infection Control and Safety issues

To ensure availability of adequate staff the following mechanisms are in place:

- Centralized Scheduling
- Human Resources
- Network Float Policies

Surgery pre-procedure area

A modified Primary Nursing model for delivery of care is utilized in the pre-procedure care unit. The RNs are cross-trained to work in the admission, procedure and recovery areas. All required to maintain a level of competence. The RN is competent to admit, assess and administer care to a pre-procedure patient of any level of acuity or complexity. The LPN is required to maintain competency to administer care to a pre-procedure patient of any level of acuity or complexity under the direction of an RN. If the patient's identified needs require more nursing resources and additional RN/LPN is utilized to assist. Support personnel are available to assist the RN/LPN. This unit is routinely staffed by RNs Monday through Friday at:

- CHE, 6:00a.m. – 5:00p.m.
- CHN, 5:00a.m. – 9:30p.m.
- CHS, 6:00a.m. – 7:30p.m.
- CHA, 7:00a.m. – 5:00p.m.

Surgery

All procedures are assigned a minimum of one monitoring/circulating RN. Demands of each procedure room schedule will be optimally matched with skills and expertise of assigned competent staff. Assignment of additional personnel will be provided as necessary with consideration to:

- Need for hospital scrub, RN, CST
- Acuity/complexity or procedure
- Physician request
- Special equipment, i.e. laser

One credentialed laser nurse will be assigned to each laser procedure with exclusive responsibility to laser operations the exception being laser ophthalmic procedures. General anesthesia services are provided by Anesthesiologists. The surgical area is open for routine procedures from 7:00a.m.–6:30p.m. Monday through Friday, at CHA 7:30a.m. – 6p.m. Outside of normal working hours emergency coverage is provided by on-call terms.

PACU (Phase I)

PACU I utilizes a modified Primary Nursing model for delivery of care. With this model an RN takes primary responsibility for assessing and addressing a specific patient's needs during his/her stay in the PACU. A Charge Nurse is assigned on a daily basis to coordinate care and activities. Primary care is delivered by an RN. All PACU RNs are ACLS certified with re-certification completed biannually.

A certain level of competence is required by all RNs in the PACU, therefore, each is deemed competent to care for a patient of any acuity/complexity. Although assignments of patients are based on ASPAN standards for patient classification, each patient receives care on the basis of assessment of needs. Clinical technicians assist with designated duties under the directions of the RN. This unit is routinely staffed Monday through Friday at:

- CHE, 6:00a.m. – 10:00p.m.
- CHN, 5:00a.m. – 6:00p.m.
- CHS, 8:00a.m – 7:30p.m.
- CHA, 7:00a.m. – 6:00p.m.

Outside of working hours care is provided by on-call teams.

PACU (Phase II)

PACU II utilizes a modified Primary Nursing model that also represents the care delivery system in PACU I. All RNs are required to maintain a level of competence to provide care to a patient of any level of acuity or complexity. Support personnel are available to assist the RN. Assignment of care is based individually on the assessed patient needs. The unit is routinely staffed for surgery 8:00a.m. – 9:00p.m. Monday through Friday at CHE and 6:00a.m-10:30p.m Monday through Friday at CHN. Hours of operation at CHS for surgery are 6:00a.m. – 7:30p.m. Monday through Friday. At CHA hours of operation are 6:00a.m. – 10:00p.m. Outside of normal working hours care is provided by on-call teams.

VI. Standards/Guidelines for Surgical Services Practice

Standards and Guidelines for Practice are utilized to provide care and include but are not limited to the following:

- Patient Care Pathways
- Professional Practice Model
- Patient Rights Handbook
- Advanced Practice Committee Guidelines/Recommendations
- Unit based guidelines for patient care that include:
    - ASPAN

- AORN
- SGNA

- Hospital Policy and Procedure
- External Licensing Regulations and Accrediting Body Standards

VII. Methods to assess and meet patient needs

- Nursing process
- Admission assessment forms
- Risk screens/pre-admission clinic
- Pathway implementation
- Patient satisfaction surveys
- Follow-up phone calls
- Cost comparisons
- LOS comparisons
- Outpatient admission rates
- Review scope of care (III and IV)

VIII. Identification of MAJOR internal and MAJOR external customers

Internal

- Employees
- Physician
- Other Departments

External

- Payer/employers
- Patients/significant others
- Community at large
- Physician offices

IX. Patient/significant other education

Teaching Protocol

This education will be age specific to include the following:

- Patient rights and responsibilities
- Estimated or schedule time for surgery/procedure
- Monitors to be utilized patient identification protocol
- Anesthesia related teaching by appropriate professionals, i.e. Registered Nurse, Anesthesiologist
- Explanation of peri-operative environment and safety procedures
- Post procedure destination
- Usual recovery time with exceptions and patient/family participation expectations
- Time and location family/significant other may resume visitation
- Assurance that needs will be met, i.e. warm blankets, pain relief and antiemetic therapy

- Possibility of O_2 therapy per their need
- Instruction of pain scale 0 – 10
- Validation of understanding patient/family/significant other of education with documentation
- All other educational needs will be individualized as needed per specific procedure, i.e. SCDs, PCAs, crutch training and drains
- All education is reinforced to patient, family and significant other prior to discharge and documented on appropriate from per unit protocol

See Scope of Care (III and IV for individualized unit patient education)

Education Tools

- Videos
- Pathways
- Tours
- Handouts

Home Care

- Education built into pathway

Surgical Services patient follow-up

- Outpatient procedures will receive a follow-up phone call within 24-48 hours of working business days. This will give the patient customer opportunity to voice questions, allow reinforcement of physician direction and identify satisfaction as well as opportunities for improvement.
- A letter will be sent to those outpatients who are not reached 24-48 hours of working business days post procedure by phone after 2 attempts.
- Opportunities for improvement are specifically identified through patient satisfaction questionnaires.

Plan Formulated By: _____

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Approved by: _____ Date: _____

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Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 3/2013

NPP#: ORSPP: P-02
Page 1 of 2
EFFECTIVE: 6/13/13

TITLE: Pre-operative PROTOCOLS FOR THE REGISTERED NURSE

Performed by: RN Caring for patient scheduled for an Operative Procedure

Purpose: To provide pre-operative care direction via protocols for the Registered Nurse (RN) providing Care to the patient scheduled for an operative procedure

Policy Statements:
1. The protocols listed in this policy are specific to OPERATIVE procedures and may be initiated by the RN prior to a scheduled procedure. THESE PROTOCOLS DO NOT APPLY TO ANY PATIENT OUTSIDE OF THE OPERATIVE/SURGICAL AREA.
2. Each protocol requires a medical order to initiate the pre-operative protocol. The protocol selected will be the protocol that matches the type of procedure scheduled. The RN may delegate specific tasks from the protocol to other staff within their scope of practice.
3. RN's working in the preoperative area of care must complete competency verification on the process of initiating and implementing pre-operative protocols.
4. If a patient is scheduled for a procedure and the procedure is included in one of the attached lists, then the RN will initiate that pre-operative protocol for that specific procedure. (SEE ATTACHED LISTING OF PROTOCOLS). If pre-operative protocol is not on the list of approved protocols then the RN must contact the surgeon to have him/her enter Pre-operative orders.
5. Pre-operative protocol orders will be initiated for all patients unless there are specific orders from the physician to not initiate the protocol order set. See listing of pre-operative protocols.
6. The RN must verify patient allergies prior to administering any medication.

General Information:
1. All orders entered for the pre-operative patient by protocol must be later cosigned by the procedural physician.
2. Additional information pertaining to specific procedures may be obtained from those specific procedure policies.

Equipment:
1. Order entry through Care Connect (select order entry, go to order set and select appropriate pre-operative protocol that matches the surgical procedure) and select ordered "as per protocol".

Procedure:
1. Initiate appropriate protocol based on the specific procedure that is scheduled.
2. Place the pre-operative orders by the using the approved associated operative protocol, on behalf of the procedural physician, who will later cosign these orders. The "Per Protocol" mode will be used for placement of these orders.
3. Monitor patient based on the protocol initiated, response to the protocol, and other physician orders.

Documentation Guidelines:
Document in Care Connect for Order Entry
Document Assessment on patient designated flow sheets within Care Connect
Document all medications on the electronic MAR

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Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
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CANCELS: 3/2013

NPP#: ORSPP: P-02
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EFFECTIVE: 6/13/13

Approved:	Dr. Michael Venturini	
Approved by:	Amy Glover Vice President Surgery and Surgery Services	Date: 3/14/13
Approved by:	Risk Management	Date: 4/10/13
	Infection Prevention:	Date: 4/10/13
Approved:	NPP Steering Committee	Date: 4/10/13

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 9/24/10

NPP#: P015A
Page 1 of 2
EFFECTIVE: 6/13/13

TITLE: SURGICAL/SPECIAL PROCEDURE CHECKLIST

Performed by: RN, LPN, PSP, PST,

Purpose: To provide guidelines for completion of the Surgical/Special Procedure Checklist.

Policy Statements:

1. Checklist must be completed on all patients having a surgical, endoscopic, or special procedure done (eg cardiac cath, coronary angioplasty procedure, etc). EXCEPTION: Bedside procedure.
2. Consent must be signed by patient or designee for surgery, endoscopy, cath lab or special procedure, prior to receiving any pre-operative sedation.
3. Isolation status must be noted.
4. Blood consent must be signed if T & C or T & S is ordered.
5. Vital signs, O_2 saturation must be taken no more than four hours before procedure, or administration of pre-op medication. (See NPP#: T-006, TPR). Vital signs must be documented in computerized patient record.
6. Pregnancy status is assessed on all fertile female patients prior to a surgical procedure scheduled with general anesthesia, IV sedation or regional anesthesia. Patients who have had a hysterectomy or are pre-menses or post menopausal are not tested. A patient may sign a "Waiver of Pregnancy Testing" to waive pregnancy testing. If waiver is signed, the surgeon and/or anesthesiologist are to be notified. For patients who have had a tubal ligation, a pregnancy test is required, or a waiver must be signed and recorded in the surgery checklist.
7. Consent for anesthesia is needed for any procedure requiring an anesthesiologist.
8. All allergies must be listed.
9. Armband and Allergy band must be placed on patient.
10. Last oral intake must be documented.
11. Ensure that IV site is functioning.
12. Body piercing jewelry is to be removed.
13. Surgical site needs to be clipped and marked by surgeon prior to leaving the pre-op area.

General Information:

1. Height and weight are needed by Anesthesia personnel to determine dosages on pre-op medications and anesthesia during Surgery. Obtain patient's weight on day of surgery.
2. If patient using tampons during menses, remove and apply peri-pad and disposable binder gauze stretch panties.
3. Patient to wear hospital gown only. Remove all under garments.
4. Anesthesia prefers all jewelry including body piercing jewelry be removed prior to surgery. If patient is unable to, or refuses to, remove any rings, cover stones with gauze and bands with tape/band-aid. Advise patient that ring may be cut off in surgery.
5. If patient does not have own contact lens case, a case may be obtained from CSR at CHE, CHN, CHS and from Emergency Room at CHVH.
6. If IV site is nonfunctioning notify the surgical team.
7. RN assesses need to obtain blood glucose level before patient leaves unit.
8. Complete appropriate department computerized or code white paper checklist.
9. Patient is transferred in bed or on cart with O2, if needed.
10. When paper form utilized: If surgery, endoscopy, or cath lab procedure is cancelled, write cancelled on checklist and retain with chart.
11. If there are any orders or instructions additional to the checklist, document addition as a note in computerized patient record or transcribe into Additional patient Information Section on Community Health Network Surgical/Special Procedures Checklist paper document.

12. In the event of a code white, complete the Community Health Network Surgical/Special Procedures Checklist N36 1009 ESI#5372 form that is printable and located in e-forms.

References: Internal Policy

Approved by:	Med/Surg NPP Committee	Date: 5/2013
	Infection Prevention	Date: 6/4/2013
	Risk Management	Date: 6/4/2013
Approved by :	NPP Steering Committee	Date: 6/12/13

TITLE: ADMISSION TO SURGERY (PRE OPERATIVE CARE UNIT)

Performed by: RN, LPN, Surgical Technician

Purpose: To provide guidelines for the admission and preparation of a patient for surgical interventions performed in the OR Services Department.

Policy Statements:
1. This admission process is followed for outpatients, short stay patients, extended recovery patients, and AM admit patients.
2. The Perianesthesia Patient Care Pathway is initiated at the time of admission.
3. The patient will not be taken back to the surgery suite unless the H&P is available.
4. Refer to HIPAA Manual for policies of privacy and confidentiality.

General Information:
1. The surgeon's office notifies the surgery scheduling office of the date of surgery, time of surgery, planned operative procedure and desired anesthetic type.
2. The surgeon's office instructs the patient on arrival time and location, NPO status, pre-op medications, and miscellaneous instructions.
3. The surgeon provides the Pre Operative Care Unit with patient orders and history/physical data. If these are not available when the patient is admitted, the admitting RN contacts the surgeon for them.
4. The surgeon's office may send the patient to pre-register, obtain preoperative testing, or attend the Pre Op Clinic before the surgery date.
5. The admission assessment is recorded on either the Peri-Anesthesia patient Data Assessment Short Form, Admission Data Base- Surgery, or Admission Data Base-Pediatrics Form (refer to PACU: A-5). An RN may complete portions of the Admission Data Base prior to the patient's admission following the guidelines for clinic/telephoned patients. Use appropriate computer documentation where applicable.

Equipment: None

Procedure:
1. The patient registers at the specified facility and is directed to the Pre Operative Care Unit.
2. Welcome the patient, introduce yourself, establish patient identification, and apply the ID bracelet.
3. Verify transportation home if outpatient or extended recovery patient.
4. Initiate ordered preoperative testing (eg labs, ECG etc.) or locate results of pre-admission testing, review results, and place on patient chart.
5. Complete and document the patient assessment.
6. Instruct or assist patient to change into hospital attire.
7. Secure valuables as outlined in (ADM.F-005F) "Patient Valuables Procedures".
8. Verification checklist documentation initiated.
9. Briefly orient patient and significant others to the unit and the expected sequence of events for the day including teaching.
10. Relay patient information to the anesthesiologist, if one is scheduled for the procedure.
11. Review test results and relay any abnormal values to the physician.
12. Verify that the chart is complete and ready for surgery.

Documentation Guidelines:
Document on the Admission Data Base, Admission Assessment, Flow sheet, the Perianesthesia Patient Care Pathway, and any additional information in the Multidisciplinary notes. At Community Hospital North access the computer documentation. Document on the Admission Data Base, Admission Assessment, Flow sheet Pathway. Document any additional information in the Multidisciplinary Notes.

References:
ADM.F-005F "Patient Valuables Procedure"
CLN-2098, Surgery/Invasive Procedure Site Verification

Formulated by:	Perioperative NPP Committee	
Approved by:	Perioperative Policy/Procedure Committee	Date: 1/9/12
	Infection Control	Date: 1/11/12
	Risk Management	Date: 1/11/12
Approved:	NPP Steering Committee	Date: 1/11/12

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
APPROVED FOR: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 11/10/10

NPP#: C-048
Page 1 of 2
EFFECTIVE: 6/13/14

TITLE: CRITERIA FOR SENDING PATIENTS DIRECTLY FROM SURGERY TO CRITICAL CARE UNIT

Performed by: RN

Purpose:
1. To provide optimal safety for patients transferring directly from surgery to the critical care unit.
2. To identify patients appropriate for direct transfer to the critical care unit from surgery.
3. To identify the responsibilities of the patient caregivers when transferring a patient from surgery to the critical care unit.

Policy Statements:
1. After receiving notification, the person coordinating patient placement will work together with Surgical Services to determine the appropriate time for transfer as well as determining adequate time between multiple patients being transferred to the Critical Care Unit.

General Information:
Patient types appropriate for direct transfer to critical care from surgery include, but are not limited to, the following:
1. Patients sent to surgery from the critical care unit for a minor procedure, having received local anesthetic, IV sedation or regional anesthetic not expected to have a change in preoperative sensorium postoperatively.
   Examples: Patients who are comatose, intubated patients to OR for tracheostomy.
2. A patient whose medical/surgical condition is such that the anesthesiologist and primary care physician agree immediate return to the critical care unit is in the best interest of the patient. (Example: Patient is mechanically ventilated)

Equipment: Portable monitoring equipment and oxygen based upon patient condition.

Procedure:
1. Notify the critical care unit as soon as possible that the patient is a potential candidate for direct transfer/return to the Critical Unit.
2. Call the receiving nurse at least 30 minutes before the patient is transported to the unit.
   Report includes:
   A. Patient Name
   B. Surgeon
   C. Procedure
   D. Isolation status, if any
   E. Vital signs, hemodynamic status
   F. Location of peripheral IV's
   G. Pressure Lines
      1) Swan
      2) Arterial
   H. Drains
   I. Medication Drips (ie: dopamine, nitro etc.)
   J. I&O – including blood loss
   K. Ventilator settings
   L. Surgical/Medical complications
   M. Anesthesia
   N. Approximate time of arrival to the Critical Care Unit.

4/2

3. Surgical Services personnel monitor and transport the patient to the critical care unit, give report to the receiving nurse, and assist the receiving nurse as needed.
4. After transfer, Surgical Services personnel ensure family has been notified of the patient's transfer.

Documentation Guidelines: Document in patient's electronic medical record

Reviewed by:	PACU Staff/Critical Care Staff	Date: 6/2014
Approved by:	Peri-operative NPP Committee	Date: 6/2014
	Anesthesia CHN/CHE/CHS	Date: 6/2014
	Infection Prevention	Date: 6/2014
	Risk Management	Date: 6/2014
Approved:	NPP Steering Committee	Date: 6/11/2014

Community Health Network

CORPORATE CLINICAL POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] TIHH
CANCELS 1-23-09

CORP#: CLN-2098

EFFECTIVE: 4/19/12

TITLE: SURGERY/INVASIVE PROCEDURE SITE VERIFICATION/UNIVERSAL PROTOCOL

Purpose:
To provide the safest possible surgical and procedural care for all patients in Central Indiana by providing guidelines for the verification and documentation of correct patient identity, procedure, surgical site and time-outs.

Policy Statements:
1. All persons to be identified by two patient identifiers (name and date of birth).
2. All procedures in surgical and non-surgical/procedural settings, including bedside procedures will require surgery/invasive procedure site verification.
3. A physician will designate in the consent for surgery/invasive procedure order, the correct site of the procedure.
4. The physician, physician's order, history and physical, consent and schedule (if applicable) must all designate the same site.
5. The patient will sign consent for surgical and/or other treatment that is consistent with the physician's order. No abbreviations are permitted.
6. If there is a discrepancy among the schedule, the consent for surgical and/or other treatment, the physician's order, history and physical, the physician will be contacted immediately for clarification.
7. No patient or Perioperative personnel will be allowed to mark the site.
8. All patients will have the site of surgery identified by the physician on the day of surgery prior to being brought to the operating suite or procedural area.
9. The intent will remain to have every patient marked by the physician prior to the beginning of any surgery/ invasive procedure. If the patient is marked prior in the office the mark must be visible the day of surgery.

General Information:
1. Marking the site for verification is required by The Joint Commission, AAAHC, HFAP, and the Indianapolis Patient Safety Coalition. It is recommended by the American Academy of Orthopedic Surgeons, Sentinel Event Safety Alerts and is endorsed by more than 40 professional medical associations and organizations.
2. Marking the site:
   A. Write, "YES" on site.
   B. If the surgeon opts to indicate his/her initials at the site marking it will be in addition to the "YES".
3. At a minimum, mark all cases involving right/left distinction, including bilateral sites, multiple structures (fingers, toes, lesions), or multiple levels (spine).

   Exceptions:

   A. To Site Marking
      a. Teeth must be identified and documented on appropriate record using either a dental radiograph or a dental diagram.
      b. Premature infants, for whom the mark may cause a permanent tattoo.
      Interventional procedures where the catheter/instrument insertion site is not predetermined.
      c. Cases where it is technically or anatomically impossible or impractical to mark the site (mucosal surfaces, perineum, or obvious deformities).
      e. An alternative method for visual identification of correct side and site may be used.
      f. Placement of a temporary unique wrist band on the

side of the procedure containing patient's name
and use of a second identifier for the intended procedure and site.

4. Cases where there is an immediate threat to life that would preclude site marking.
5. If the surgical site is a traumatic site or obvious, it does not have to be marked (single site suturing).
   B. To Time-Outs
      a. cases where there is an immediate threat to life that would preclude all but the following:
      b. An abbreviated time-out may be performed to verify patient identity, correct site and side.
6. The surgical site marking will take place in a pre-operative or pre- procedural area. No site marking will be done in the same room in which the surgery or procedure takes place. A "time-out" for final verification must still occur. (Refer to Time-Out prior to initiation of procedure).
   - Exemption:
     - Cases in which the individual doing the procedure is in continuous attendance with the patient from the time of decision to do the procedure and consent from the patient through to the conduct of the procedure may be exempted from the site marking requirement. The requirement for a "time out" final verification still applies.

Equipment:
Single use marking pen (indelible ink)

Procedure:
Pre-operative unit/area

1. With the patient or representative involved, awake and aware if possible, the RN or procedural team member preparing the patient will verify the patient's identity using two (2) forms of identification; and verify the surgical procedure, location, any known allergies, a Consent for procedure has been signed and the H & P is verified as current, and updated if applicable. Any discrepancies found must be reported to the physician immediately.
2. With the patient or representative involved, awake and aware if possible, the operative site(s) is to be marked prior to the patient leaving the pre-operative area.
3. The site may only be marked by the physician performing the procedure and will be present at the time the procedure is performed.
4. The site is to be marked with the word "YES" to indicate appropriate site using a single use skin marker that is sufficiently permanent to remain visible after completion of skin prep and sterile draping. In addition, the physician may place their initials adjacent to the "YES" marking.
5. Sites are required to be marked with regard to laterality (right vs. left distinction), multiple structures (fingers, toes), and general spinal regions (cervical, thoracic, lumbar). Incision sites in the mid-line or though a natural orifice must be marked with laterality noted for paired structures.
6. The pre-op RN or procedural team member will verify the marked site with the physician's order, the Patient's Consent for Surgery and /or other Treatment, surgical/invasive procedural consent, history and physical, and schedule.
7. The RN or procedural team member will complete the documentation in the medical record on the Surgery/Invasive Procedure Site Verification Checklist. Exception: (See Documentation Guidelines, #1 Attachment A & #2). The checklist verifies the following items are available and accurately matched to the patient: correct diagnostic and radiology test results, any required blood products, implants, devices and/or special equipment if applicable; also relevant documentation regarding patient identity and procedure(s) to be performed.

Upon arrival in the pre-op/ procedural area

1. The surgical RN or procedural team member will verify the patient using two patient identifiers; the identified site with the physician's order, history and physical, surgery/invasive procedure consent prior to documenting on the Surgery/Invasive Procedure Verification Checklist.
2. The surgical RN or procedural Team member will verify if correct test and X-Rays are available, blood if needed and correct devices and equipment including implants The patient may then be transported to the surgery/invasive procedure area, after above is verified.

First "Time- Out"

1. Upon entry into the OR or procedural area the patient will be identified with two patient identifiers.
2. The procedure to be performed and any allergies verified.

3. There will be verbal acknowledgement from all members in the room.

Second "Time-Out" prior to initiation of procedure

1. Immediately prior to the initiation of the procedure, with the full surgical team present, the physician will initiate the time-out. If the physician does not take ownership of this process, the circulating RN or procedural team member will be charged with initiating this process.
2. The time-out involves verbal acknowledgement by every member of the team where any member is open and able to express concerns about procedure verification.
3. The initiator of the Time-out will verbally verify with the entire team:
   - Correct patient identity using two (2) patient identifiers.
   - Agreement on the procedure to be performed and accurate consent has been signed
   - Correct side and site have been visibly marked if applicable and correct patient position
   - Verify and document the name of the pre-operative antibiotic (if applicable) and the time it was started
   - Confirm the need to administer antibiotics or fluids for irrigation purposes if applicable
   - Confirm any safety precautions based on patient history or medication use if applicable
   - Verify all relevant images and results are properly labeled and appropriately displayed
   - Address the antibiotic if given; Yes it was given (or not, drug dosage, route, and time).
4. If any verification process fails to identify the correct site by any member of the team, all activities are halted until the discrepancy can be resolved and documented.
5. The entire time-out process is to be documented in the medical record.
6. When a single patient is undergoing multiple procedures that include a change in position/physician/procedure than a time-out is conducted just prior to each change. Each time-out is documented separately.

Closing "Time-out" and verification of counts

1. Prior to closure (if applicable) the physician, or circulating RN or procedural team member will initiate a time-out to verbally confirm:
   a. A review of surgical consent and procedures completed
   b. All specimens are identified, accounted for (visualized in the container) and accurately labeled
   c. All foreign bodies have been removed

Documentation Guidelines:

1. Document and complete the Surgery/Invasive Procedure Site Verification Checklist. See Attachment A.
2. Document any discrepancies and the action(s) taken in the appropriate form.
3. Complete the appropriate electronic health record or paper.

References:

Accreditation Association Ambulatory Health Care Accreditation Standards 2011, Chapter 10, Surgical and Related Services
The Joint Commission Universal Protocol and Guidelines for Preventing Wrong-Site, Wrong Procedure, Wrong Person Surgery, 12/03
AORN Position Statement on Patient Safety, Standards, Recommended Practices, and Guidelines, AORN 2011
AORN Position Statement on Correct Site Surgery, AORN Standards 2011
American Academy of Orthopedic Surgeons Advisory Statement of Wrong-Site Surgery. (AAOS On-Line Service, Wrong-Site Surgery)
Indiana Surgery Center, Indianapolis, Site Verification Policy, 1/10
Sentinel Event Alerts, 8/98; 12/01
2012 National Patient Safety Goals, the Joint Commission
Indianapolis Patient Safety Coalition Policy Universal Protocol 2008

Formulated by:
Verification Site Leadership Group, Chiefs of Anesthesia E/N/S, Executive Directors Indiana Surgery Centers, Medical Directors Indiana Surgery Centers, Vice President Surgical Services, Indianapolis Patient Safety Coalition, Chief Medical Officer VEI

Owner: Florence Miller, RN, CAPA
Regulatory Coordinator Surgical Services

Approved by: Peri-operative Nursing Subcommittee Group
Infection Prevention
Risk Management
Date: 4/12

Approved for Distribution: CNO Designee
Date: 4/12

Approved: _____
Chief Operations Officer
Date:

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE NPP: C-47
APPROVED FOR: [X] CHE [X] CHN [X] CHS [X] CHVH Page 1 of 9
CANCELS: 11/10/10 EFFECTIVE: 4/30/13

TITLE: COUNTS: SPONGES, SHARPS, NEEDLES, INSTRUMENTS

Performed by: RN, LPN, Student Nurse Extern, Student Surgical Tech, Certified Surgical Tech, Surgical Tech I, Equipment Prosthesis Coordinator, Private Scrub

Purpose: To outline a consistent and efficient method to account for all instruments, surgical sponges and sharps used during a specified surgical procedure.

Policy Statements:

A. The major goal of counting is to provide safe, appropriate care to the surgical patient; therefore, careful attention to the surgical count(s) is essential. Retention of a foreign object can cause life threatening injury to the patient and increase the liability of the surgeon, OR staff and the facility.
B. Accountability for surgical counts is the responsibility of the entire team, including the surgeon, anesthesiologist and circulating and scrub staff.
C. Circulating and scrub staff are required to complete the counts audibly for the entire team to hear. This communication is essential to patient safety.
D. Any item that is not counted will not be placed in the wound.
E. The type of case will determine if counts are needed, and what is to be counted.
F. Counts on sponges, surgical sharps/needles, and other small items should be performed:
    1. Before the procedure to establish a baseline.
    2. Whenever performing a prepfor a cavity case, ie, vaginal, rectal or wound staff are required to use an RF tagged raytex sponge or a disposable sponge stick. RF tagged sponges are required to be counted before and after the prep and also included in the overall sponge count process for the procedure.
    3. Before the closure of a cavity within a cavity.
    4. Before wound closure begins.
    5. At skin closure or at the end of the procedure.
G. Instrument counts should be performed (when applicable):
    1. Before the procedure to establish a baseline.
    2. Before the closure of a body cavity. Often this count accompanies the first sponge and sharp(s) count.
H. For those sites that utilize RF Technology, the RF Detection System does not replace the need for a manual, verbal, and/or visual sponge count. See separate departmental policy for the RF Detection System if sponges are being utilized at your site, for timing of scan(s), frequency of use, and types of cases in which the technology will be implemented.
I. If the staff members who did the original count are leaving this procedure and not returning,, then a new count(s) should be initiated with the new team members (although direct visualization of all items may not be possible).
J. The circulator records the count on a count worksheet. This worksheet will be used to keep accurate records during the operation. The worksheet will be discarded at the end of the case.
K. The surgeon and anesthesiologist should be informed of each count.
L. The circulator is responsible for accurately documenting the counts on the operative record.
M. In the interest of patient safety, no patient will leave the OR until all indicated counts have been completed and confirmed with the surgeon.
N. A Confidential Peer Review report will be initiated for any count discrepancy.

General Information: None.

Equipment: None.

Procedure:

A. Sponges:
   1. Surgical sponges to be counted included:
      a. Laparotomy sponges (laps) 5/unit
      b. Raytex 10/unit
      c. Kitners 5/unit
      d. Tonsils 5/unit
      e. Cottonoids 10/unit
      f. Section sponges (tails) 5/unit
      g. Any radiopaque sponge
      h. Blue towels if they are placed in the wound – 1 per unit.
   2. Count all surgical sponges prior to the start of the procedure. **Exception:** Surgical sponges do not have to be counted on arthroscopic procedures, cataract extraction, retinal detachments, or vitrectomy procedures. The circulator records the count on a count worksheet. Following this count, do not remove any sponges, trash or linens from the Operating Room.
   3. Sponges may be counted as total number of sponges. When counting in units, you must validate the total number of sponges.
   4. The scrub discards raytex, laparotomy and section sponges from the operative field either onto a designated area on the floor (drop cloth) or into a plastic lined kick bucket.
   5. Kitners, cottonoids, or tonsil sponges should remain on the field until a complete unit (as described above) is assembled. Once two members of eth OR team have counted those sponges, they may be passed off the sterile field and bagged.
   6. The circulator opens and lays the discarded sponges in units in an orderly fashion, on a designated area to ensure that no sponges are hidden within one another, and to facilitate estimation of blood loss on the sponges.
   7. Each sponge should be separated from the other sponges so the radiopaque marker is visible on each sponge.
   8. An RN and another individual count aloud and in unison with both concurrently viewing each sponge as it is counted.
   9. After the initial count, any additional sponges should be counted and recorded in the same manner.
   10. If a radiopaque sponge is cut or trimmed, account for it in its entirety. This includes strings off laparotomy sponges.
   11. Sponges may be bagged in units, per department protocol, with the consent of the anesthesiologist and/or surgeon. Counter bags may used when appropriate.
   12. If the "unit" of sponges does not contain the exact number of sponges as specified above, do not use that unit of sponges. Scrub passes the unit to the circulator who secures them in a plastic bag and removes them from the Operating Room. Do not record them on the count worksheet.
   13. Complete closing counts:
      a. At the start of closure of any deep, or large incision or body cavity
      b. At the completion of closure of any body cavity
      c. At the start of the closure of the outermost layer (eg skin)
   14. **Exceptions:** If a large organ is opened (eg uterus or bladder), perform an additional closing count as the surgeon begins to close the organ.
      Perform closing counts in this order:
      a. Operative field
      b. Mayo stand
      c. Back table

d. Sponges discarded off of the sterile field

15. For those sites that have implemented RF technology, please refer to your departmental protocol on the timing and frequency of scanning the patient.
16. If the staff member who did the original count are leaving this procedure and not returning, then a new count(s) should be initiated with the new team members (although direct visualization of all items may not be possible). This extra count will be completed before both of the original staff members, the circulator and scrub, leave the case.
17. Inform the surgeon and the anesthesiologist of the results of each sponge count.
18. The circulator records the results, quantity of counts, and the name and title of persons performing the counts on the operative record.
19. If a radiopaque surgical sponge is used as packing, the circulator records the location and type of sponge on the operative record.
20. If the count is incorrect
    a. Notify the surgeon, anesthesiologist and/or charge nurse.
    b. Recount the sponges
    c. Immediately perform a search of the field and/or room (eg trash, hampers, floor of the operating room, etc.)
    d. If available, utilize RF technology to scan the patient and/or trash and linens (per departmental protocol).
    e. Surgeon will search the wound and/or cavity as appropriate.
    f. Call for an X-ray of patient (while patient is still in the OR and under anesthesia) under the guidance of the surgeon/anesthesiologist.
    g. Circulator enters "incorrect" on the operative record and documents actions on a multidisciplinary note.
    h. Complete a Confidential Peer Review report.

B. Surgical Sharps/Needles/and Other Small Items:
1. Surgical sharps to be counted included (but not limited to):
    a. Suture needles
    b. Scalpel blades
    c. Hypodermic needles
    d. Electrosurgical tips
    e. Safety pins
    f. Items such as bovie scratchers, vessel loops bulldog clamps, etc. are counted at the discretion of the OR personnel
2. The procedure for counting surgical sharps/needles and/or other small items follow the same count procedure as sponges. Sponge and sharp counts should occur at the same time. See policy statement.
3. Count all surgical sharps prior to the start of the procedure. **Exception:** Hypodermic needles do not have to be counted on cataract extraction, retinal detachments, or vitrectomy procedures. Count suture needles according to the number marked on the outer package. An RN and another individual count aloud and in unison with both concurrently viewing each sharp as it is counted. The circulator records the count on a count worksheet. Following this count, do not remove any sharps, trash or linens from the Operating Room.
4. The scrub validates the actual number of suture needles when the package is opened.
5. Count and record any sharps added after the initial count in the same manner.
6. If a surgical sharp is broken, account for it in its entirety.
7. Complete closing counts:
    a. At the start of closure of any deep, or large incision or body cavity.
    b. At the completion of closure of any body cavity.

c. At the start of the closure of the outermost layer (e.g., skin)

Exceptions: If a large organ is opened (eg uterus or bladder), perform an additional closing count as the surgeon begins to close the organ.

8. Perform closing counts in this order:
   a. Operative field
   b. Mayo stand
   c. Back table
   d. Sharps discarded off the sterile field
9. If the staff members who did the original count are leaving this procedure and not returning, then a new count(s) should be initiated with the new team members (although direct visualization of all items may not be possible). This extra count will be completed before both of the original staff members, the circulator and scrub, leave the case.
10. Inform the surgeon and anesthesiologist of the results of each sharp count.
11. The circulator records the results, quantity of counts, and the name and title of persons performing the counts on the operative record.
12. If the count is incorrect:
    a. Notify the surgeon, anesthesiologist and/or charge nurse.
    b. Recount the sharps
    c. Immediately perform a search of the field and/or room (eg trash, hampers, floor of the operating room, etc.)
    d. If the sharp is not located, the surgeon may search the wound and/or cavity as appropriate.
    e. An X-ray of patient may be performed (while patient is still in the OR and under anesthesia) under the guidance of the surgeon/anesthesiologist.
    f. Circulator enters "incorrect" on the operative record and documents actions on a multidisciplinary note.
    g. Complete a Confidential Peer Review Report.

C. Instruments:
1. Count instruments on all procedures entering the peritoneal, retroperitoneal, thoracic cavities and open heart procedures on all patients weighing greater than 25 pounds. **Exception:** (a) An instrument count does not have to be done on laparoscopic procedures unless an open laparotomy is planned or another cavity is entered.
2. Instruments will be counted when sets are assembled for sterilization. This assembly count provides a basic reference for the instrument set and is not considered the initial instrument count.
3. Initial counts in the OR will be performed to establish a baseline for subsequent counts.
4. An RN and another individual count aloud and in unison with both concurrently viewing each instrument as it is counted. The circulator records the count on a count worksheet.
5. Count and record any instrumentation added to the overall count.
6. Account for any instruments disassembled or broken in their entirety.
7. If the staff members who did the original count are leaving this procedure and not returning, then a new count(s) should be initiated with the new team members (although direct visualization of all items may not be possible). This extra count will be completed before both of the original staff members, the circulator and scrub, leave the case.
8. If there are multiple procedures on a patient that require more than one set of instruments, count all opened instruments/sets (if one of the procedures falls into the guidelines for instrument counts listed above).
9. Complete one closing instrument count with first sponge and sharp(s) counts.
10. Additional counts may be performed at the discretion of OR personnel when they deem necessary, or if significant risk for leaving instruments within the operative site exists. Document any counted

instruments removed from the Operating Room during a surgical procedure on the count worksheet.

11. Inform the surgeon and anesthesiologist of the accuracy of each instrument count.
12. The circulator records the results, quantity of counts, and the name and title of persons performing he counts on the operative record.
13. An X-ray done at the closing of any procedure entering the peritoneal, retroperitoneal,, thoracic, or pericardial cavities eliminates the need to perform an instrument count, but counting is preferable if at all practical. The X-ray will include entire body cavity involved, and will be performed just after all retractors are removed.
14. In an emergent situation, counts are not considered a priority, although an X-ray will be required at the end of the case. If time permits, counting is preferable to ensure patient safety.
15. If the count is incorrect:
    a. Notify the surgeon, anesthesiologist and/or charge nurse.
    b. Recount the instruments. It can be beneficial to have another scrub count for you.
    c. Immediately perform a search of the field and/or room (eg trash, hampers, floor of the operating room, autoclave, etc.)
    d. Surgeon will search the wound and/or cavity as appropriate.
    e. Call for an X-ray of patient (while patient is still in the OR and under anesthesia) under the guidance of the surgeon/anesthesiologist.
    f. Circulator enters "incorrect" on the operative record and documents actions on a multidisciplinary note.
    g. Complete a Confidential Peer Review report.

Documentation Guidelines: The number and results of counts are recorded on the Operative Record. Actions taken will be documented on the Multidisciplinary Notes. Discrepancies will be initiated on a Confidential Peer Review Report.

References: AORN Standards and Recommended practices, 2010
National Institute for Occupational Safety and Health, Publication no. 97-111, January, 1998

Approved by:	Perioperative NPP Subcommittee	
	Risk Management	Date: 3/13/13
	Infection Control	Date: 3/13/13
	CHVH	Date: 3/13/13
Approved:	NPP Steering Committee	Date: 3/13/13

TITLE: RF (Radio Frequency) SURGICAL DETECTION SYSTEM

Performed by: RN, LPN, Certified Surgical Tech (CST), Student Nurse Extern, Surgical Tech student, Private Scrub who are competency verified.

Purpose: To verify a correct sponge count as well as to provide additional safety against accidental sponge retention within a surgical wound.

Policy Statements:

1. Use of the RF Surgical Detection System does not replace the need for a manual, verbal, visual sponge count (NPP: C-47).
2. The RF Detection System will be used for the following procedures:
   a.) All open cavity (thoracic, abdominal, pelvic)
   b.) Hand-assisted thorocoscopy, colectomy, thorocotomy, nephrectomy, etc.
   c.) All emergent cases in which an initial sponge count was unable to be attained.
   d.) All incorrect sponge counts
3. The RF Detection System should NOT be used on patients with Automatic Internal Cardiac Defibrillator (AICD); VAD; permanent pacemaker, or any procedures that are scheduled with intraoperative magnet usage.
4. The RF Detection system will be used prior to final wound closure as well as after skin closure. A minimum of (2) scans must be done.
5. RF tagged surgical sponges (raytecs and lap sponges) will be the only sponge type stocked and used within the department.

Equipment:

1. Radio Frequency (RF) tagged raytec sponges and lap sponges.
2. Reusable hand-held Blair-Port Wand RF Surgical detection wand
3. RF Surgical Detection Console

Procedure:

A.) Calibration of Console

1. At the start of closure of the incision or body cavity circulating nurse and scrub nurse will perform a manual/visual sponge count.
2. The sterile surgical wand will be opened to the sterile field.
3. Circulator turns the RF Console to the "ON" position.
4. Circulator will plug the RF wand into the RF Console.
5. Scrub nurse will hold the wand above the patient in order to calibrate the wand.
6. The green light will illuminate indicating the system is ready for use.
7. The scrub nurse will test wand with an RF detect sponge by looking and listening for alarm.

B.) Appropriate adjustments to the settings of patient medical devices must be made before beginning the scanning procedure. **Temporary pacers must be in Non-Demand Mode. ***

C.) Scanning Procedure must include both a vertical and horizontal scan and each pass of the wand should take approximately 3 seconds to complete.

1. Vertical Scan (See Attachment A)
   a.) Position wand parallel to the body as close as possible.
   b.) With wand remaining parallel to the body, move the wand distally from head to toe (Pass #1).
   c.) When at the toe, continue to move wand parallel to body up to the left shoulder (Pass #2)
   d.) With wand parallel to the body, move wand down the left side of body (Pass #3).
   e.) Keeping wand parallel to body continue from the left foot in a diagonal motion across the body to the right shoulder (Pass #4).
   f.) Keeping wand parallel to patient's body, continue from the right shoulder down the right side of patient's body (Pass # 5).
   g.) Keeping wand parallel to the patient's body, the final pass will return the wand from the lower right side of body up to the head (Pass #6).

2. Horizontal Scan: (See Attachment A)
   a.) Position wand parallel to body on lateral side of torso beginning at the shoulder.
   b.) Keeping wand parallel to body, move wand in an arc motion to opposite side of torso. (Pass #1 right shoulder to left shoulder).
   c.) Keeping wand parallel to body, move wand in an arc motion to opposite side of torso (Pass #2 left shoulder to right abdomen).
   d.) Keeping wand parallel to body, move wand in an arc motion to the opposite side of torso (Pass #3 Right abdomen to left abdomen).
   e.) Keeping wand parallel to body, move wand in an arc motion to the opposite side of torso (Pass #4 Left abdomen to right iliac region).
   f.) Keeping wand parallel to body, move wand in an arc motion to the opposite side of torso (Pass #5 Right ileac region to left ileac region).

C.) If the presence of an item is identified by the RF Surgical Detection System, begin exploring the incision or cavity and repeat scanning procedure until all sponges are accounted for.

D.) The patient and all linen and waste containers will be scanned according to the RF scanning procedure to locate missing surgical sponges in order to resolve the final count

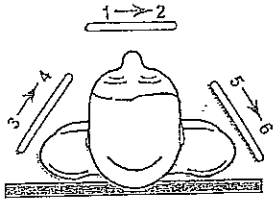
E.) If unable to locate missing sponge with RF wand, follow the procedure for incorrect counts in nursing policy NPP:C-47.

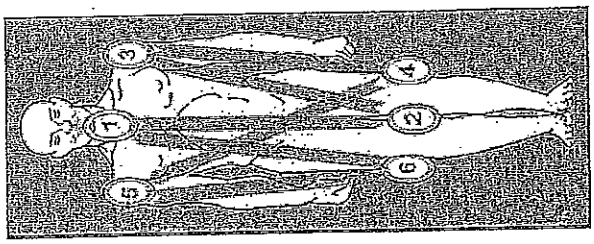
Documentation Guidelines

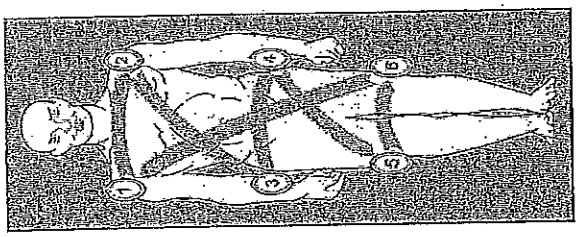
The number and results of counts performed by the Perioperative Team are recorded on the Operative Record. Documentation of usage of the RF Surgical Detection System must be written in the Multidisciplinary Notes. Discrepancies will be initiated on a Confidential Peer Review Report.

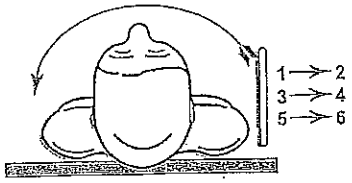
References

1.) Evidence for Practice. (2007). Radio frequency identification and surgical Detection. *Association of PeriOperative Registered Nurses Journal*, 85 (3), 638-639.
2.) Jackson, S. & Brady, S. (2008). Counting difficulties: Retained instruments, Sponges, and needles. *Association of PeriOperative Registered Nurses Journal*, 87 (2). 315-321.
3.) RF Surgical™ Detection System Model 100A Rev 5 Owners Manual; RF Surgical Systems Inc.









Pictures provided by FR Surgical™ Systems Inc.

426

CHS Sponge Counting Protocol

1) Sponge counts should be taken:
   a. - Before the procedure to establish a baseline (initial count)
   b. - Before closure of a cavity within a cavity
   c. - Before wound closure begins
   d. - At skin closure or end of procedure

2) Initial count:
   a. – Sponges should be separated, counted audibly, and concurrently viewed during the count procedure by the scrub nurse and the circulating nurse.
   b. – The circulating nurse should document the initial sponge count at this time.

3) During the procedure:
   a. – All contaminated sponges shall be discarded from the surgical field to a floor drape.
   b. – The circulating nurse shall separate the contaminated sponges on the floor drape and maintain them in an orderly fashion. Sponge counter bags for sponge separation are NOT permitted.

4) Before closure of a cavity:
   a. – Prior to closure of a cavity, the first sponge count shall be performed. The count should begin at the surgical site and the immediate surrounding area, proceed to the mayo stand and back table, and finally to sponges that have been discarded to the floor drape.
   b. – Sponges should be counted audibly and concurrently viewed during the count procedure by the scrub nurse and the circulating nurse.
   c. – If discrepancy the circulating nurse shall inform the surgeon, otherwise the circulating nurse shall document first sponge count correct at this time.

5) Before wound closure begins:
   a. – Prior to wound closure, the second sponge count shall be performed. The count should begin at the surgical site and the immediate surrounding area, proceed to the mayo stand and back table, and finally to sponges that have been discarded to the floor drape.
   b. – Sponges should be counted audibly and concurrently viewed during the count by the scrub nurse and the circulating nurse.
   c. – If discrepancy the circulating nurse shall inform the surgeon, otherwise the circulating nurse shall document second sponge count correct at this time.

6) At skin closure or end of procedure:
   a. – At skin closure or end of procedure, a third/final sponge count shall be performed. The count should begin at the surgical site and the immediate surrounding area, proceed to the mayo stand and back table, and finally to sponges that have been discarded to the floor drape.
   b. – Sponges should be counted audibly and concurrently viewed during the count by the scrub nurse and the circulating nurse.
   c. – If discrepancy the circulating nurse shall inform the surgeon, otherwise the circulating nurse shall document third/final sponge count correct at this time.
   d. – Surgeon shall be informed by circulating nurse that all sponge counts are correct.

7) Permission for sponge disposal:
   a. – Anesthesia shall view sponges for estimated blood loss and give permission for disposal.

Community
Health Network

June 9, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that the Laboratory supports Community South Hospital's effort to complete the "in the process" Level III Trauma Center Requirements. Subsequently, we will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

We further understand that our role is to ensure that laboratory services are available twenty-four hours per day at Community South Hospital. This includes the standard analyses for blood, urine, and other body fluids, including micro sampling when appropriate. Our lab services also include coagulation studies, blood gasses, and microbiology.

Respectfully,

Gabrielle Houston, MLS(ASCP)
Laboratory Manager

Michael Sever, M.D.
Laboratory Medical Director

Edward J. Diekhoff III, M.D.
Trauma Medical Director

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 17

Post-Anesthesia Care Unit (PACU)

17. "**Post-Anesthesia Care Unit.** The post-anesthesia care unit (PACU) must qualified nurse and necessary equipment 24 hours per day. Documentation for this requirement must include a list of available equipment in the PACU."

Narrative Response and Discussion

The requirements of section 17 are met with a signed letter from the Director of Surgical Services and Anesthesia Section Chairman affirming the PACU has met the requirements for Level III Trauma Center requirements. Also included are policies and equipment list for the PACU.

Community
Health Network

Community Hospital South
Emergency Department
1402 E. County Line Road
Indianapolis, Indiana 46227-0963
317-887-7200 (tel)
eCommunity.com

June 17, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of the correspondence is to inform the committee that I am the Director of Surgical Services. I am pleased to support Community Hospital South's effort to complete "in the process" Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I further understand that my role is to ensure that qualified nurses and all necessary equipment are available twenty – four hours per day in the Community Hospital South Post Anesthesia Care Unit.

Respectfully,

Patrick Beaupre RN, BSN
Director Surgical Services

Edward Diekhoff, M.D., F.A.C.S.
Trauma Medical Director

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June 17, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of the correspondence is to inform the committee that I serve as Anesthesiologist Chairman. I am pleased to support Community Hospital South's effort to complete "in the process" Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I confirm that qualified nurses and all necessary equipment are available twenty – four hours per day in the Community Hospital South Post Anesthesia Care Unit.

Respectfully,

Andrew Corsaro, M.D.
Anesthesia Chairman

Edward Diekhoff, M.D., F.A.C.S.
Trauma Medical Director

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 3/21/053/25/08

NPP#: PACU: E-001
Page 1 of 2
EFFECTIVE: 8/12/13

TITLE: RESPONSIBILITIES OF (PACU) PERI-ANESTHESIA CARE UNIT REGISTERED NURSES IN EMERGENCIES

Performed by: RN

Purpose: To outline the nursing guidelines for the emergency treatment of patients in the PACU when no anesthesiologist is available.

Policy Statement:
In the event of an emergency, when no anesthesiologist is in attendance, PACU RNs can initiate these protocols/interventions. The orders listed within this policy may be initiated by RN prior to physician notification.

General Information:
PACU RNs are verified as an ACLS provider and re-verified every two years. Emergency situations include acute chest pain, hypotension, questionable or life threatening cardiac rhythms, an acute change in respiratory status, cyanosis, symptoms of hypoglycemia, increased bleeding.

Equipment:
1. Monitoring equipment (ECG, Blood Pressure, Pulse Oximetry)
2. Crash Cart
3. Defibrillator
4. POC testing (iSTAT) if available.

Procedure:
1. The RN initiates the following measures as the patient condition warrants:
   a. Obtain a stat 12 lead ECG for acute chest pain or questionable cardiac rhythms.
   b. Start 2-4L of 0_2 per nasal cannula for acute chest pain, questionable cardiac rhythms, or acute change in respiratory status or cyanosis.
   c. Obtain a stat chest x-ray for acute changes in respiratory status, cyanosis, or to check central line placement.
   d. Obtain a stat arterial blood gas for acute changes in respiratory status or cyanosis.
   e. Check the patient's blood sugar by using the bedside glucometer.
   f. Obtain a stat hemoglobin and hematocrit for an acute episode of bleeding or hypotension.
   g. Check the patient's electrolytes by using the iSTAT (if available) or obtain a STAT electrolyte or serum potassium for cardiac arrhythmia.
   h. Start an IV infusion of Lactated Ringers/Normal Saline at a continuous rate, or start a Saline lock for IV access for patients with chest pain, cardiac arrhythmia, hypotension, or changes in respiratory status or cyanosis

2. Per ACLS protocol, the nurse initiates the American Heart Association treatment protocols for asystole, ventricular fibrillation, ventricular tachycardia or symptomatic bradycardia.
3. Notify attending anesthesiologist immediately.
4. At CHE and CHN if the anesthesiologist is unavailable, notify the house staff doctor. At CHS, notify the Emergency Department.

Documentation Guidelines:
Document patient assessment, intervention, responses, and communication/attempts at communication with physicians, and patient responses on the multidisciplinary notes, Post Anesthesia Care Unit record. Write orders for initiated treatments, medications, and intravenous fluids on the physician's order sheet.

References:
American Heart Association Advanced Cardiovascular Life Support Provider Manual, 2010.

Formulated by:	PACU Staff	
Approved by:	Perioperative NPP Subcommittee	
	Infection Prevention	Date: 7/13
	Risk Management	Date: 7/13
Approved:	NPP Steering Committee	Date: 7/10/13

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 4/2/10

NPP#: PACU-E03
Page 1 of 2
EFFECTIVE: 5/1/14

TITLE: EXTUBATION IN THE POST ANESTHESIA CARE UNIT

Performed by: Competency Verified Post Anesthesia Care Unit RNs

Purpose: To provide guidelines for the extubation of patients in the Post Anesthesia Care Unit

Policy Statements:
1. Extubation is done only if an anesthesiologist is available for re-intubation if necessary.
2. Re-Intubation equipment must be immediately available on the unit prior to extubation.
3. RNs will not suction through a laryngeal mask airway unless an anesthesiologist is in attendance.
4. Prior to extubation, the patient's respiratory status must meet the following criteria:
   a. Respiratory effort spontaneous.
   b. Respiratory rate, depth and pattern sufficient to maintain an O2 saturation above 90% (with or without supplemental oxygen). If the preoperative level was less than 90%, the saturation must be equal to, or better than, the preoperative level.
   c. Skin color or mucous membranes pink
   d. Bilateral breath sounds audible to auscultation.
5. Prior to removal of an endotracheal tube, the patient must meet at least 2 of the following criteria:
   a. Be able to open their eyes
   b. Stick out their tongue
   c. Move their extremities
   d. Sustain a five second head lift
   e. Demonstrate airway protective reflexes (eg swallow, gagging)
6. Prior to removal of a laryngeal mask airway, the patient must be able to open their mouth and/or stick out their tongue.

General Information:
1. Extubation in the Post Anesthesia Care Unit includes the removal of an endotracheal tube or a laryngeal mask airway.
2. Potential airway complications, such as partial or complete obstruction, or laryngospasm, may occur post extubation.
3. The suctioning of pooled pharyngeal secretions before deflating the cuff on the endotracheal tube decreases the chance of aspiration and laryngeal irritation.
4. Stimulation of a patient with a laryngeal mask airway may cause premature rejection of the airway-this includes suctioning the patient.
5. There is a danger of laryngospasm when suctioning through a laryngeal mask airway.
6. If the anesthesiologist is in agreement, the laryngeal mask airway can be removed without deflating the cuff.

Equipment:
1. Suctioning equipment (oral/endotracheal)
2. Bag/valve mask unit
3. Oxygen supply source and delivery system (eg nasal cannula, face tent, trach mask)
4. Syringe for cuff deflation (10 ml for endotracheal tube, 20 ml for adult Laryngeal mask airway)
5. Gloves
6. Protective eye coverings

Procedure:
1. Apply personal protective equipment including protective eye wear.
2. Perform respiratory assessment.

3. Perform level of consciousness assessment.
4. Prepare suction equipment for usage.
   a. Use sterile procedure for the set up of suction of endotracheal tubes.
   b. Use clean procedure for the set up of the oral or nasopharynx.
5. Loosen tape.
6. If necessary, suction endotracheal tube and/or oral naspopharynx.
7. Deflate the cuff using a syringe (10 ml for endotracheal tube, 20ml for laryngeal mask airway).
8. Instruct the patient to take a deep breath.
9. Remove the endotracheal tube or the laryngeal mask airway during end inspiration using a smooth outward motion. If a bite block is in place, remove the artificial airway first, then the bite block. This prevents the patient from biting the airway and causing an obstruction.
10. Apply oxygen, if needed, to maintain the patient's oxygen saturation greater than 90% (or equal to preoperative level if preoperative level was less than 90%), unless otherwise ordered by the physician.
11. Re-assess respiratory status and document in the electronic medical record.
12. Instruct the patient to take deep breaths to maintain oxygen saturation levels at greater than 90%, or equal to preoperative levels.
13. Instruct the patient to cough as necessary to clear the airway.

Documentation Guidelines:
Document on the Post Anesthesia Care Unit Record in the electronic medical record.
Respiratory assessment

References: Core Curriculum for Peri-Anesthesia Nursing Practice 2nd edition; Schick/Windle 2010.
Peri-Anesthesia Nursing, A Critical Care Approach; Cecil B. Drain 6th edition; 2012

ASPAN Standards of Peri-Anesthesia Nursing Practice 2012 - 2014

Approved:	Peri-Operative NPP Committee	Date: 4/2014
	Infection Prevention	Date: 4/2014
	Risk Management	Date: 4/2014
Approved:	NPP Steering Committee	Date: 4/9/2014

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 4/2/10

NPP#: T-034
Page 1 of 2
EFFECTIVE: 6/13/14

TITLE: TRANSPORTATION TO AND FROM SURGERY AND/OR PACU

Performed by: RN, SE, CST, SST, Clinical Technicians

Purpose:
To provide guidelines for transporting from surgery or PACU.

Policy Statements:
1. An RN must accompany a monitored patient during transport.
2. If the PACU personnel are unable to leave the PACU to transport the patient, the nursing unit will be notified and arrangements made for transfer of the patient by unit personnel.

General Information:
1. Patient care needs are identified by communication between departments (ie oxygen, monitors).
2. Patients may be transported via a cart, wheelchair, or patient bed.

Equipment:
Vehicle for transportation-cart, wheelchair or bed, Surgery call slip.

Procedure:
1. Transportation to Surgery
   a. For non scheduled procedures, surgery personnel notify the nursing unit of their anticipated arrival time.
   b. Surgery personnel inform the staff on the nursing unit that he/she has arrived to transport the patient to surgery.
   c. Surgery personnel verify the identity of the patient, check the chart for completeness, and review the pre-op checklist.
   d. Surgery personnel assist in transferring the patient to the cart or wheelchair, if necessary, and transport the patient to the Surgical Services Department and instruct the patient's visitors on where to wait.
   e. For weekend cases the patient may be transported by house supervisor or nurse taking care of patient directly to surgery.
   f. Surgery personnel transport any physiologically monitored patient with at least two (2) people one of which has to be an RN.

2. Transportation to the Nursing Unit from Surgery or PACU
   b. Give report to the receiving RN either by phone, or in person upon transfer to the patient's room. Report include, but is not limited to:
      1. Surgical procedure
      2. Physical status and vital signs
      3. IV site, condition, and fluids
      4. Drains
      5. Intake and Output
      6. Stat or special orders for the nursing unit
      7. Orders transcribed in PACU
      8. Level of consciousness
      9. Patient concerns
      10. Meds given if any
      11. Equipment as necessary

c. PACU: Verify and document that discharge criteria are met. Complete all sections of the Post Anesthesia Care Record and complete all orders specific to PACU.
d. PACU: Empty all drains, foley catheters etc., unless otherwise ordered by the physician.
e. Upon arrival to the nursing unit, the surgical services personnel and the receiving nurse assist the patient to transfer to their bed (if necessary). Leave the bed in the low position, side rails up, and wheel locks secured unless the receiving nurse requests otherwise. After report is given vital signs are taken by receiving personnel and documented by both RNs. Vital Signs include but are not limited to, blood pressure, temperature, pulse, O_2 Saturation and respirations. Leave the chart with the receiving nurse unless otherwise directed.
f. Surgical Services personnel notify the surgery waiting room of the patient's return to the room. If unable to locate the patient's family/significant other, surgical services personnel informs the nursing unit.
g. CHVH patients: Surgical services personnel notify the front desk to put the patient's family in a consult room for the surgeon to discuss the surgery. Surgery notifies surgeon of consult room.

Documentation Guidelines:
Document in the electronic medical record

References: NPP - PACU: A-2

Approved by:	Perioperative NPP Subcommittee	Date: 6/2014
	Infection Prevention	Date: 6/2014
	Risk Management	Date: 6/2014
Approved:	NPP Steering Committee	Date: 6/11/2014

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 4/2/10

NPP#: PACU-D02
Page 1 of 2
EFFECTIVE: 8/9/13

TITLE: DISCHARGE CRITERIA, PACU

Performed by: RN

Purpose: To provide guidelines for the discharge of patients from the Post Anesthesia Care Unit.

Policy Statements:
1. The order to discharge a patient from the Post Anesthesia Care Unit is written by the anesthesiologist. If no anesthesiologist was present for the procedure (e.g., IV Sedation by the nursing staff or physician), the surgeon writes the order to discharge the patient from the Post Anesthesia Care Unit.
2. A specific order from the anesthesiologist is required to discharge a patient who does not have an Aldretti score of at least 9.
3. An adult patient's oxygen saturation must be greater than 90% prior to discharge from the Post Anesthesia Care Unit (unless their preoperative oxygen saturation was less than 90%).
4. If the patient's preoperative oxygen saturation was less than 90%, their oxygen saturation must be within 2 % points of that preoperative level prior to discharge from the Post Anesthesia Care Unit.
5. A patient's temperature is defined as documentation of active warming used intraoperatively or a least one body temp >96.8 F/36C within 30 minutes immediately prior to or the 15 minutes immediately after anesthesia end time. (Surgical Care Improvement (SCIP) 10 with Perioperative Temperature Management) or within two degrees (Fahrenheit) of their preoperative temperature prior to discharge from the post Anesthesia Care Unit.
6. Adult patients must have three consecutive blood pressure readings within 20% of their pre-anesthesia readings prior to discharge from the Post Anesthesia Care unit.
7. Pediatric patients must have apical heart and respiratory rates within 20% of their pre-anesthesia readings with an Aldretti score of 2 on "level of consciousness." (Is this a national guidline? Feel like this is not always followed)
8. The patient's pain level must be assessed prior to discharge. The patient may be discharged if their pain level is 4 or less, acceptable to the patient, or if ongoing pain management orders are on the chart.

General Information:
1. Inpatients undergoing operative procedure with only local anesthetic may go directly back to their inpatient unit without being admitted to the Post Anesthesia Care Unit.
2. Inpatients receiving IV sedation may be transported directly back to their inpatient unit ONLY if they have not received sedation within the last 30 minutes and they meet the discharge criteria outlined in CORP#: CLN 2052, "Conscious Sedation."
3. May refer to NPP M2.35 "Epidural Analgesia: Monitoring and Care of Patients Receiving."

Equipment:
Blood pressure cuff with sphygmomanometer and stethoscope, or noninvasive blood pressure unit with appropriate size cuff, or arterial line with appropriate monitoring device.
Cardiac Monitor
Pulse Oximeter
Thermometer
Stethoscope

Procedure:
1. Complete the patient assessments.
2. Complete documentation as outlined in NPP PACU I A-1 "Post Anesthesia Care Unit Record."

3. If patient does not meet the above criteria for discharge, notify the anesthesiologist. If anesthesia determines that the patient is to be discharged without meeting the criteria, document the order as given.
4. Report to the next caregiver receiving the patient. After report is given, vital signs will be taken by admitting personnel and documented by both RNs. Vital signs include but are not limited to blood pressure, temperature, pulse, O_2 saturation and respirations.

Documentation Guidelines:
Document on the PACU Patient Care Flowsheet, the multidisciplinary notes, the neurovascular checklist, Symptom Management Tool

References:
CORP#: CLN 2052 "Conscious Sedation"
NPP PACU A-1 "Post Anesthesia Care Unit Record"
NPP M 2.35 "Epidural Analgesia: Monitoring and Care of Patients Receiving"
Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements: 2012-2014 ASPAN

Approved by:	Perioperative NPP Committee	0
	Infection Prevention	Date: 7/13
	Risk Management	Date: 7/13
Approved:	NPP Steering Committee	Date: 7/10/13

QUALITY/SAFETY MANAGEMENT PLAN
ENDOSCOPY SERVICES

Community Hospital North
Community Hospital South
Community Hospital East
Community Hospital Anderson
Indiana Heart Hospital

July 2011

Community Hospitals of Indiana, Inc.
Quality Safety Management/Scope of Service Plan
Endoscopy Services

The purpose of this document is to provide the operational link to the Network Organizational Performance Improvement and Safety Plan.

I. Mission/Vision/Values Statements

Mission

The mission of Endoscopy Services is to be a leader in providing a full continuum of services to the community serviced by the Community Health Network. We will be central Indiana's most preferred inpatient and outpatient Endoscopy service provider and we will deliver unsurpassed service to our physicians and their patients. In partnership with our medical staff, we offer innovative and individualized Endoscopy options that are responsive to our customer's needs. We are committed to efficiently and safely delivering the highest surgical care, creating an exceptional experience for physicians, patients, families, and employees.

Vision

It is the objective of Endoscopy Services to accomplish our mission by partnering with physicians, patients, families, and employees. We will benchmark performance indicators and major processes. We will creatively develop new approaches and alternative delivery systems offering state of the art technology for the best demonstrated practices in Endoscopy services. These continuous improvements will result in a system that will provide high quality services as evidenced by total customer satisfaction.

Values

Patients First: We believe that patients' needs, and the needs of their families, are our number one priority.

Relationships: We are inclusive, working together as partners and teams.

Integrity: We expect truth-telling and transparency.

Innovation: We foster creativity and openness to new ideas.

Dedication: We are accountable stewards of the resources entrusted to us.

Excellence: We provide access to a high quality and safe environment of care, known for high performance.

Community's statement of values is all about making our organization the best it can be—providing the most exceptional experiences possible for patients and families, opening our

doors to all who desire our services, building the health care workplace of choice for central Indiana, creating exceptional experiences for physicians, ensuring that our organization is efficient and fiscally healthy. We can't succeed as a team unless we all live our values, which we remember with the acronym PRIIDE.

Business Growth

We strive to continually grow out business by creating the most surgeon-oriented Endoscopy facilities in the Midwest. We provide our patients with the strongest blend of quality, service, and price, making our facilities the customer's and payer's best value for Endoscopy care.

Financial Performance

We focus on the delivering of safe and cost-effective health care through efficient use our resources.

II. Goals of patient care service

The goal of Endoscopy is to be a leader in providing a full continuum of services to those individuals served by Community Health Network. We will strive to exceed our customer's expectations by continuous improvement to ensure flexibility, accessibility to our schedule, high quality, and responsible cost.

III. Types and ages of patients served

Endoscopy serves both inpatient and outpatient populations for gastroenterology and pulmonary procedures. These services are tailored to the patients needs based on age: children, over the age of 12 and weighing more than 100 lbs., adolescents, adults, and senior adults. Evidence of age specific competency is performed annually during the staff PA process.

IV. Scope and complexity of need

Endoscopy procedures are provided in different locations dependent on patient needs: CHE Endoscopy Department is located in the Surgery Department.

- ERCP procedures are performed in Radiology
- Critical patients in the ICU are performed at the bedside
- Intra-operative Endoscopy procedures, pediatric patients according to policy, and any procedures requiring general anesthesia are immediately available within the department.
- Emergent outpatient procedures are performed in the Emergency Department
- Procedures involving MAC sedation are performed by anesthesia in the Endoscopy Department and/or the Operating Room.

V. Extents to which the level(s) of care or service provided meets patient needs/Methods used to assess and meet customer's needs:

The patient's needs are met consistently by providing the same level of care at all times. This is accomplished by providing on call services for emergency procedures after working hours, weekends, and holidays. On call staff is available as follows:

- Monday through Friday after 1700 – one Endoscopy trained nurse available for emergent cases performed at the bedside in selected areas with the assistance of the beside RN. At CHS two personnel are available (one Endoscopy trained nurse and the other an RN or CST trained in Endoscopy).
- Weekends and holidays – one Endoscopy-trained nurse 0700-0700, with second nurse available during 4 hour period 0800-1200 each day. The second on call nurse is available to assist with medical patients who meet the criteria and whose procedure can be safely performed in the Endoscopy Department. At CHS two Endoscopy trained personnel are available for a 24 hour period on weekend and holidays.
- On call staff at CHE can be contacted through the hospital switchboard at or by the physician himself. On call staff at CHN is contacted through the hospital switchboard at by the physician himself. On call staff at CHS can be contacted through the hospital switchboard at or the physician himself can call the surgery department. Information required by on call staff includes patient name, procedure to be performed, patient location, special equipment needed, and any additional information associated with the patient's care.
- On call staff has 45 minutes travel time and will begin setting up the care immediately upon arrival.

Methods to assess and meet customer's needs:

Patient surveys are performed on a random basis by the hospital marketing department, and the results are shared with the Endosopy department and staff. Outpatient procedure patients receive a follow up phone call within four days of their procedure allowing them to express satisfaction as well as improvement opportunities. The Quality Assessment/Risk Management Department share information reported on peer review reports or in regard to risk issues. Peer review reports, patient safety issues, the patient compliant, and resolution process also provide information as to how patient needs are met.

VI. Appropriateness, clinical necessity, and timelines of support services provided directly by the organization or through referral contacts

Endoscopy services are provided by a multi-disciplinary professional staff, which includes but is not limited to:

- Endoscopists
- Pulmonologists
- Registered Nurses
- Licensed Practical Nurses
- Certified Surgical Technologists
- Support Techonologist

In addition, clinical support is provided by Respiratory Care, Pharmacy, Radiology, Laboratory, Materials Management, Finance, and Information Systems as needed.

The administration for Endoscopy includes the Executive Director, Clinical Director and Nurse Manager. Other resource personnel available to the administrative team include a Financial Consultant and a Human Resource Representative.

VII. Availability of necessary staff

Pre-procedure care is provided utilizing a Primary Nursing Model. The RN's cross-trained to work in the admission, procedure, and recovery areas. All are required to maintain a level of competence. The RN is competent to admit, assess, and administer care to a pre-procedure patient of any level of acuity or complexity. The LPN is required to maintain competency to administer care to a pre-procedure patient of any level of acuity or complexity under the direction of an RN. If the patient's identified needs require more nursing resources, an additional RN is utilized to assist. Support personnel are available to assist the RN/LPN. This areas is routinely staffed by RN's Monday through Friday 0700-1700.

All procedures are assigned a minimum of one monitoring RN and one RN/LPN/CST to assist the Endoscopist. The staff is employed by Community Health Network. Demands of each procedure room schedule will be optimally matched with skills and expertise of assigned competent staff. The Endoscopy area is open for routine procedures from 0700-1700. Outside of normal working hours, emergency coverage is provided by on call nurses.

The Endoscopy admit/recovery area utilized a Primary Nursing Model for delivery of care with a 3:1 RN ratio for the care of patients in this area. All RNs are required to maintain a level of competence to provide care to a patient of any level of acuity or complexity. Support personnel are available to assist the RN. Hours of operation for Endsocopy are 0700-1700 Monday through Friday.

VIII. Recognized standards or guidelines for practice when available

Standards and guidelines for practice are utilized to provide care and include are not limited to the following:

- Patient Rights Handbook
- SGNA Standards
- ASPAN Standards
- Hospital Policy and Procedures
- External Regulatory Standards

XI. Methods that are used to assess and meet patient needs, including staffing effectiveness indicators as appropriate

- Nursing process
- Admission assessment documentation
- H&P's, ASA risk screens
- Patient satisfaction surveys
- Follow up phone calls

X. Identification of MAJOR internal and MAJOR external customers

Internal

- Employees
- Physicians
- Other departments

External

- Payers/Employers
- Patient/Significant others
- Community at large
- Physicians offices

XI. Patient/Significant other education

This education will be age specific to include the following:

- Patient rights and responsibilities
- Scheduled time for procedure
- Monitors to be utilized
- Sedations related teaching by appropriate professions, i.e. RN, Physician
- Explanation of safety procedures
- Post procedure destination
- Usual recovery time
- Possibility of O_2 therapy if needed
- Instructions regarding pain scale 0-10
- Documentation of understanding of education by patient/family significant other
- All education is reinforced to patient, family, and significant other prior to discharge and documented on appropriate form
- Outpatient procedures will receive a follow-up phone call within 4 days. This will give the patient customer an opportunity to voice questions, allow reinforcement of physician instructions as needed, and identify satisfaction as well as opportunities for improvement

- A letter will be sent to those outpatients who are not reached by phone. CHN & CHE Endoscopy does leave generic messages on answering machine and voicemail when performing follow-up phone calls.
- Written materials including preprinted information sheets on diagnosis, additional procedures, and diet are given at discharge
- Verbal descriptions of what procedures entail prior to procedure performance

XII. Safety management

The safety management measures may be different at each phase of the Endoscopy experience. Handoff communication with a time to ask and respond to questions will always be a part of the process. The following are the safety measures taken for patients in the Endoscopy area:

Pre-Procedure:

- Determine availability of responsible adult and transportation arrangement
- Apply patient identification/allergy band always using the 2 patient identifier process
- Establish and maintain IV access as necessary
- Keep side rails on cart up during patient transport, after IV sedation has been given, when cart is in position other than low, and as patient condition or mentation requires.
- Report to procedure nurse and/or MD will include allergies, and pertinent clinical information gathered during assessment.

Intra-Procedure:

- Ensure immediate availability of necessary reversal agents and age-appropriate resuscitation equipment.
- Verify patient identification using the 2 patient identifier process and procedure planned using the site verification and "time out" process
- Remove dental prosthesis if applicable
- Review and read back all MD orders for moderate sedation
- MD and RN must be immediately available at onset of IV medication administration
- Check IV site patency prior to medication administration and every 15 minutes during procedure. Run IV fluids at a rate to facilitate medication administration or use appropriate amount of normal saline IVP with each medication.
- Transport to post procedure area with IV lock or IV fluids at keep open rate and portable oxygen as necessary
- Report to post procedure nurse to include IV drugs and dosages administered, pertinent clinical information related to procedure phase, and MD findings as appropriate

Post-Procedure:

- Side rails to remain up on cart until patient meets discharge criteria and/or as patient condition requires
- Maintain IV access until level of consciousness improves and patient is able to tolerate fluids, as appropriate.

- Offer patient PO fluids when clinical condition indicates or as directed by MD, i.e. cough/gag reflex present, able to swallow, passing fluids, eructating, presence of normoactive bowel sounds.
- Ambulate patient initially with assistance of Endoscopy staff to determine stability. Additional activity may be assisted by responsible adult at discretion of RN.
- Observe patients who have received reversal agents for a minimum of 2 hours to ensure resedation does not occur. Maintain IV access until patient meets discharge criteria.
- Inpatients will be offered PO fluids post endoscopy as approved by physician. Report to an inpatient's nurse will be given according to hand-off communication policy.

XIV. Quality Initiatives

Endoscopy will incorporate Joint Commission Patient Safety Goals into patient care and department operations and monitor staff compliance. Compliance is expected to be at 100%. Deviations will be identified and actions taken. Examples of performance measures include:

- Handwashing
- 2 patient identifiers
- Procedural time out
- Moderate sedation
- Patient satisfaction
- Quality control monitoring will be performed according to manufacturers guidelines
- Moderate sedation audits

Plan formulated by: _____

_____

_____

Approve By: _____ Date: _____
Name and Title

Approve By: _____ Date: _____
Name and Title

Approve By: _____ Date: _____
Name and Title

Approve By: _____ Date: _____
Name and Title

PACU EQUIPMENT LIST

1. Bair Huggers (each room)
2. Philips Monitors with X2 portable monitors (capable of measuring artline readings)
3. I-Stat
4. Crash Cart
5. Camino monitor
6. Verathon bladder scanner
7. Doppler x2
8. Portable pulse oximetry
9. SCD's
10. Alaris IV pumps with side channels
11. Block cart x 2
12. Isolation carts x 2
13. Wound vac pumps (UHS)

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 18

Relationship with IOPO

18. "**Relationship with an organ procurement organization (OPO).** There must be written evidence that the hospital has an established relationship with a recognized OPO. There must also be written policies for triggering of notification of the OPO."

Narrative Response and Discussion

The requirements of section 18 are met with a signed copy of the agreement between IOPO and Community Health Network. Also included is the signed policy regarding organ donation.

IOPO

INDIANA ORGAN PROCUREMENT ORGANIZATION

June 11, 2014

William C VanNess II, MD -- Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Dear Dr. VanNess,

I would like to express our sincere appreciation for the collaborative partnership with Community Hospital South in regards to the lifesaving gift of organ, tissue and eye donation.

The professionalism and enthusiasm of the Community Hospital South staff and physicians has ensured the spirit of the donation process is promoted throughout the hospital and beyond. IOPO has found Community Hospital South to be a robust advocate and partner who has consistently worked to foster a compliant and innovative approach to donation.

We thank Community's Leadership and staff for their continued support and dedication to organ and tissue donation. If you have any further questions please feel free to reach out to me directly.

Warm Regards,

Steve Johnson
Chief Operating Officer
C -- 317.775.1068

IOPO

2014 Service Plans - Goals and Actions for 2014

Community Hospital (South Indianapolis)

Advocate Organ Donation as the Mission with a Focus on Change, Improvement and Results

Establish a Strong Culture of Accountability for Results

- Seek greatest organ donation areas for the hospital and work to maximize effective process
- Utilize data to set donation outcome targets and actions

Aggressive Pursuit of Every Donation Opportunity

Advocate Organ Donation as a Mission

- Provide consistent feedback regarding concerns and timely response to issues
- Educate hospital staff regarding impact of missed opportunties/families not offered

Focus on and Decrease/Eliminate Missed Opportunities

- Present missed opportunities to key contacts and donation council
- Consistent and timely follow up to staff on missed opportunities

Maximize Satisfaction to Customers

100% Customer Satisfaction

- Show appreciation to hospital staff for efforts made by communicating successes
- Request feedback on donation and referral events to make IOPO improvements
- Respond to hospital needs and requests

Maintain Relationships with Key Hospital Contacts

- Timely follow-up and information when requested
- Effective communication of successes and issues

Maximize Tissue Donation

100% of Donation Opportunities Offered by Trained Effective Requestors

- Regular review of data reports of donation key indicators with key leadership and staff

100% Timely referral of all Cardiac Deaths

- Hospital unit based education and targeted core curriculum/education to referring staff

Christy Cannon

IOPO Professional Services Coordinator

HOSPITAL PROCUREMENT AGREEMENT

(ORGAN, TISSUE AND EYE)

This Hospital Procurement Agreement (Organ, Tissue and Eye) ("Agreement") is made this 1st day of November 2010 between Community Hospitals of Indiana, Inc. and its affiliates and subsidiaries ("Hospital") and Indiana Organ Procurement Organization, Inc. ("IOPO").

RECITALS

A. IOPO is an Indiana nonprofit corporation and is a freestanding Organ procurement organization (within the meaning of 42 C.F.R. § 413.200 and § 486.302) which is the federally qualified Organ procurement organization designated for the donation service area within the State of Indiana in accordance with Section 371 of the Public Health Service Act (42 U.S.C. § 273) ("Donation Service Area");

B. IOPO is a member of the Organ Procurement and Transplantation Network ("OPTN") established under Section 372 of the Public Health Service Act (42 U.S.C. § 274), the nonprofit corporation composed of transplant centers, organ procurement organizations, and histocompatability laboratories, with the purpose of increasing the availability and access to donor organs;

C. OPTN is administered by the United Network for Organ Sharing ("UNOS"), a nonprofit corporation, which, as the OPTN contractor, manages the national Organ transplant waiting list, manages clinical data in a secure environment, works to improve the quality processes of OPTN, and facilitates the Organ allocation, matching and placement process for human Organ transplants;

D. IOPO conducts Tissue and Eye procurement services and is accredited by the American Association of Tissue Banks ("AATB"), and complies with requirements of the United States Food and Drug Administration ("FDA") in conducting Tissue and Eye procurement activities for transplantation, therapy, medical research or educational purposes;

E. The purposes of IOPO are to perform and coordinate the identification of donors, and facilitate the retrieval, procurement, preservation and transportation of Organs, Tissue and Eyes for transplantation, therapy, medical research or educational purposes, to work with the OPTN and UNOS in the allocation and placement of Organs available for transplant, and to educate medical personnel and the general public regarding donation and transplantation issues;

F. Hospital participates in the Medicare and Medicaid program and desires to be in compliance with Section 1138 of the Social Security Act (42 U.S.C. § 1329b-8) and the rules of the Centers For Medicare and Medicaid Services ("CMS") for hospital conditions of participation in Medicare and Medicaid programs (42 CFR Part 482.45);

G. For the purposes of this agreement, Hospital is defined as the facilities operated by and for Community Health Network and are designated as Community Hospital East, Community Hospital North, Community Hospital South, the Indiana Heart Hospital and are located within the Donation Service Area of IOPO;

H. Hospital agrees to cooperate with IOPO in identifying Potential Donors in order to maximize the number of usable Organs, Tissues and Eyes donated, providing Timely Referral to IOPO of Imminent Deaths and deaths which occur in Hospital; allowing families of Potential Donors to be informed of the potential for Organ, Tissue, or Eye donation; and maintaining Potential Donors under the direction and guidance of IOPO while necessary determinations of medical suitability, testing and placement of Organs can take place. Hospital agrees to cooperate with IOPO in supporting a patient's right to donate Organs, Tissue and Eyes when an appropriate declaration of gift has been made by the patient, even if that declaration of gift is contrary to the wishes of the next of kin, and, allowing IOPO to appropriately approach all families of medically suitable Potential Donors in order to obtain the consent to donate Organs, Tissue and Eyes, when appropriate, for suitable Potential Donors under eighteen years of age or where no declaration of gift can be found. Hospital hereby requests that IOPO recover all Organs from Donors who die within Hospital that are determined to meet the requirements of medical suitability; and

I. In situations where organs, tissue and eyes are determined not to be medically suitable for purposes of human transplantation, Hospital and IOPO agree that with appropriate consents, procurement may proceed for medical or dental education, research, the advancement of medical or dental science, or therapy.

AGREEMENT

NOW, THEREFORE, in consideration of the foregoing recitals, the mutual covenants contained herein and for other good and valuable consideration, the parties hereby agree as follows:

1. Definitions. For purposes of this Agreement, the following words shall have the meanings indicated herein:

a) "Brain Death" shall mean the condition of death occurring when increased intracranial pressure is sufficient to impede the flow of blood into the brain causing cellular death of the brain tissue and/or herniation; characterized by the absence of electrical activity in the brain, blood flow to the brain, and brain function as determined by the clinical assessment of responses therefore, resulting in complete, irreversible cessation of all functions of the entire brain, including the brain stem.

b) "Clinical Indicators" shall mean the following criteria for a patient with severe, acute brain injury and (i) who requires mechanical ventilation; (ii) is in an intensive care unit, critical care unit or emergency department; (iii) has clinical findings consistent with a Glasgow Coma Score that is less than a threshold of 5, regardless of central nervous system depressants or an induced coma, or for whom the attending physicians are evaluating a diagnosis of brain death, or for whom a physician has ordered that life-sustaining therapies be withdrawn, pursuant to the family's or guardian's decision.

c) "Conversion Rate" shall mean the number of Potential Donors meeting the medical suitability requirements of IOPO, who actually donate Organs compared to all eligible Organ Donors who die in Hospital, including those for whom consent to donate is not obtained, expressed as a percentage.

m) "Tissue" shall mean other transplantable and non-transplantable tissues of the human body, excluding Organs, and including but not limited to whole heart for heart valves, vascular tissue, connective tissues, skin and bones.

2. Notice of Donor Availability and Consent. Hospital shall, consistent with applicable laws and regulations, cooperate with IOPO in the recovery of Organs, Tissues and Eyes donated from patients who die in the Hospital. Hospital shall cooperate with IOPO to prepare and implement appropriate policies that support the mechanism of the donation of Organs, Tissues and Eyes.

a) Hospital shall provide Timely Referral to IOPO as soon as possible of every individual whose death is imminent or who has died (including calling prior to or at the time Brain Death is declared), in the Hospital. In addition, Hospital shall provide Timely Referral to IOPO or the named donee, if any, when Hospital becomes aware that a person in transit to Hospital is identified as a Potential Donor. IOPO shall preliminarily determine, based upon medical and patient information provided by Hospital, the medical suitability of each Potential Donor for Organ, Tissue and Eye donation according to requirements utilized by IOPO.

b) The determination of death for a Potential Donor shall be made by the Donor's attending physician or by the physician responsible for certifying death at the Hospital. Such physician shall not participate in any procedure relating to removal or transplantation of any Organs, Tissues, or Eyes. IOPO shall not participate in the determination of death of any potential Organ, Tissue or Eye Donor. Notification of a determination of death shall be written into the patient's chart upon pronouncement. IOPO shall verify the determination of death according to applicable State and federal laws prior to proceeding with any anatomical recovery.

c) Hospital shall allow IOPO to determine the medical suitability of any Potential Donor and to use such portable laboratory equipment as may be necessary to facilitate such determination.

d) Hospital shall ensure, in collaboration with IOPO and consistent with federal and state laws, rules and regulations, that a patient's right to donate Organs, Tissues, and Eyes is fulfilled when appropriate declaration of gift is noted, or that the family of each Potential Donor, or person legally responsible for a Potential Donor, is informed of the potential to donate Organs, Tissues, and Eyes, or to decline to donate when the appropriate declaration of gift cannot be found. When a family member or person legally responsible for a Potential Donor is informed about the procedures for making a gift of Organs, Tissue or Eyes, the fact that the family member or representative was so informed shall be noted in the Potential Donor's medical chart. Hospital and IOPO shall encourage discretion and sensitivity with respect to the circumstances, views and beliefs of the families of Potential Donors.

e) IOPO and Hospital shall act in good faith to support a patient's right to donate, and fulfill a patient's wishes to donate anatomical gifts in accordance with the Indiana Uniform Anatomical Gift Act, Indiana Code 29-2-16-2 et seq. (the "Act"). The Act prevents a patient's family from altering a gift declared in writing by an individual

under the provisions of the Act. Under the provision of the Act, IOPO shall attempt to obtain any documentation of patient's declared decision to donate, including applicable designations on an individual's driver's license, which may be determined from the Bureau of Motor Vehicles registry or the Donate Life Indiana registry and honor such request in accordance with applicable requirements of law.

f) IOPO shall determine whether a Potential Donor has made a written anatomical gift, and, if so, whether the Potential Donor has subsequently revoked the anatomical gift in writing, in consultation with the family or guardian of the Potential Donor and with any other sources that are reasonably available, and any information received by IOPO shall be provided by IOPO to Hospital, the attending physician, and the physician who certified the Potential Donor's death if there is not an attending physician, and must be documented in the Donor's medical chart.

g) Hospital shall work cooperatively with a Family Services Coordinator in requesting consent for any potential anatomical donation from a Potential Donor's family, when no declared intent by the Potential Donor can be found. If Hospital has actual notice of contrary intent in writing by a Potential Donor, or that the potential donation is opposed by a member of the Potential Donor's family or guardian, which member is of the same or prior class under Indiana law as the family member or guardian granting the consent, Hospital shall notify IOPO of such contrary intent. This shall not prevent IOPO from presenting options for donation to a Potential Donor's family members or guardian.

h) In the event that Organs, Tissue or Eyes are determined not to be medically suitable for purposes of human transplantation, Hospital and IOPO agree that with appropriate consent, procurement and all examinations necessary to assure suitability may proceed for donation for medical or dental research or education, the advancement of medical or dental science, or therapy.

3. Organ, Tissue and Eye Procurement. The procedures undertaken to procure donated Organs, Tissue and Eye shall be supervised by PTC, or other professional procurement personnel, provided by and or contracted by IOPO, with specialized training in transplantation, Donor evaluation and management and Organ, Tissue and Eye preservation, to coordinate Organ, Tissue and Eye procurement activities at Hospital, or, to serve as consultants to the Hospital physicians on the staff of Hospital, or when other qualified Organ, Tissue and Eye procurement personnel perform such activities. Hospital agrees to grant access, on an emergency basis in accordance with its Medical Staff rules and regulations, to physicians and other Organ, Tissue and Eye procurement personnel participating in the procurement procedures, case management, and all ancillary activities. Hospital and IOPO agree to cooperate in complying with reasonable requirements of other health care providers and payors in connection with Organ, Tissue and Eye procurement pursuant to the terms of this Agreement.

4. IOPO Obligations. IOPO, consistent with its purposes of performing and coordinating the retrieval, preservation and transportation of Organs, Tissues and Eyes will follow the system of locating prospective recipients pursuant to the rules of the OPTN for available Organs, and

educating medical personnel regarding donation issues, shall:

a) provide twenty-four (24) hour availability of a qualified IOPO staff member or PTC to evaluate and determine the medical suitability for Organs, Tissues and Eyes from Potential Donors; assist in the clinical management of the Donor, coordinate the procurement teams for Organ, Tissue and Eye recovery, provide technical assistance during recovery and initiate Organ, Tissue and Eye preservation and recovery;

b) provide twenty-four (24) hour availability of a Family Services Coordinator and/or other qualified IOPO staff member to appropriately inform the family of a Potential Donor of the right to donate or to decline to donate, to seek to obtain consent for donation from the family or person legally responsible in accordance with applicable law, and with discretion and sensitivity to the family or legal guardian.

c) provide in-service training for Hospital personnel involved in Organ, Tissue and Eye donations;

d) educate Hospital personnel regarding donation and transplantation issues;

e) if requested, approve or provide on at least an annual basis a course in the methodology for approaching Potential Donor families and requesting Organ and Tissue donation for the purposes of training Hospital personnel to become Designated Requestors, which training shall also be designed in conjunction with the tissue and eye bank community, if Hospital chooses to use Hospital personnel to perform such tasks;

f) provide a physician or other qualified and trained personnel to assist in the medical management of the Potential Donor during the time of actual procurement of Organs, Tissues and Eyes and provide assistance to physicians who are members of the Medical Staff of Hospital to provide such services, and IOPO's Medical Director shall provide oversight and assistance in the clinical management of a Potential Donor when the Hospital physician on call is unavailable;

g) ensure that IOPO personnel and IOPO contractors providing services under this Agreement are trained in the proper methods necessary for Donor screening, determining medical suitability, requesting consent for donation, procurement, transportation and preservation of Organs, Tissue and Eyes, efficient placement of Organs, Tissue and Eye, and oversight of Organ, Tissue and Eye recovery;

h) determine whether there are conditions that may influence or affect the medical suitability and acceptance of a Potential Donor;

i) to the extent reasonably practical, obtain the medical and social history of a Potential Donor;

j) review the medical chart of a Potential Donor and perform a physical examination of a Potential Donor;

k) obtain the vital signs of a Potential Donor and perform all pertinent tests, including blood typing using two separate samples from each Potential Donor;

l) document each Potential Donor's medical chart with all test results, including blood type, before beginning Organ or Tissue recovery;

m) if IOPO recovers Organs from a DCD Donor, IOPO shall maintain and follow protocols for evaluating DCD Donors; for withdrawal of support, including the relationship between the time of consent to donation and the withdrawal of support; the use of medications and interventions not related to the withdrawal of support; the involvement of family members prior to Organ recovery; and criteria for the declaration of death and time period that must elapse prior to Organ recovery;

n) provide qualified and trained personnel, materials, certain pharmaceuticals and equipment for recovery and preservation of Organs and Tissues after their procurement;

o) utilize Organs procured at Hospital in accordance with the rules and requirements of OPTN and UNOS, and requirements of law, to recipients deemed suitable in accordance with sound medical practice;

p) utilize Tissues procured at Hospital in accordance with sound medical practice and in accordance with standards recognized by the FDA and AATB;

q) if requested by Hospital, provide Hospital with information as to the eventual disposition of all Organs procured at the Hospital;

r) reimburse Hospital at a rate consistent with national Organ procurement standards that are reasonable and customary for the Indiana region as determined by American Medical Bill Review ("AMBR"), for all costs associated with procurement of Organs from Donors preliminarily approved as medically suitable from and after the time of death of the Donor is determined and proper consent is obtained, in accordance with existing applicable CMS regulations;

s) pay private physicians not otherwise compensated through Hospital for reasonable and customary procurement fees for services related to procurement activities, unless IOPO and a physician have entered into a separately negotiated agreement for charges related to procurement activities;

t) make arrangements for histocompatibility tissue testing and testing for potentially transmittable diseases according to the current standards of practice to determine the medical acceptability of the donated Organs for the purposes intended, which shall be performed by a laboratory that is certified in the appropriate specialty or subspecialty of service and meeting the requirements specified by UNOS, in accordance with the guidelines specified by the Center for Disease Control and other applicable laws and regulations;

u) send complete documentation of Donor information including Donor's blood type and other vital data necessary to determine compatibility for purposes of transportation, the complete record of Donor's management, documentation of consent, documentation of the pronouncement of death, and documentation regarding determining Organ quality to the Transplant Center that will utilize each Organ; and two individuals, one of whom must be an IOPO employee, must verify that the documentation that accompanies an Organ is correct;

v) conduct reviews, on at least a monthly basis, of death records in every Medicare and Medicaid participating hospital in its Donation Services Area that has a Level I or Level II trauma center or 150 or more beds, a ventilator and an intensive care unit (unless the hospital has a waiver to work with an Organ procurement organization other than IOPO), with the exception of psychiatric and rehabilitation hospitals; to make an assessment of the medical charts of deceased patients to evaluate the potential for Organ donation; and in the event that missed opportunities for donation are identified, IOPO, working with Hospital, shall implement actions reasonably necessary to improve performance in identifying such opportunities; w) establish written policies to address the process for identifying, reporting, thoroughly analyzing and preventing adverse events that may occur during the Organ and Tissue donation process, and use the analysis to affect changes in IOPO's policies and procedures to prevent the repetition of adverse events during Organ and Tissue donation;

w) maintain a toll-free telephone number (800-356-7757) to facilitate the central referral of Organ, Tissue and Eye donations within the IOPO Donation Service Area; and

x) either directly or through a contract with an answering service, shall cause Organ, Tissue and Eye donation referrals to be referred to IOPO and its on-call staff.

5. Additional Hospital Obligations. In addition to those obligations set forth in Section 2 of this Agreement, Hospital shall:

a) comply with the requirements of Section 1138 of the Social Security Act (42 U.S.C. § 1320b-8) and the regulations of the Centers for Medicare and Medicaid Services; all anatomical gift legislation of the State of Indiana; and other legal requirements applicable to Organ, Tissue and Eye donation;

b) allow IOPO to use ancillary laboratory facilities, other than any available at Hospital, for tests of Organ function, blood typing, and other indicated clinical studies of Potential Donors as directed or requested by IOPO;

c) maintain certification of Hospital laboratory testing under the Clinical Laboratory Improvement Amendments of 1988 ("CLIA") and regulations of the Centers for Medicare and Medicaid Services, 42 C.F.R. Part 493.

d) in a timely manner provide intensive care or other clinical support for optimum maintenance of Potential Donors prior to Organ, Tissue and Eye procurement, to follow procedures and protocols as specified by IOPO for Organ, Tissue and Eye procurement;

and work cooperatively with IOPO in the optimum maintenance of Potential Donors while necessary testing and placement of potential donated Organs takes place;

e) shall adopt a protocol for DCD Donors, and notify IOPO of Hospital's DCD protocol, and to take all steps required under such protocol for determinations of death as provided in subsection 5. (f) below;

f) in a timely manner provide physicians to determine the death of Potential Donors in compliance with applicable state law and in accordance with standard medical practice;

g) work cooperatively with IOPO on providing access to Potential Donor medical records, in providing appropriate access to Hospital's information system;

h) provide IOPO with wired or wireless secure high-speed internet connection within the Hospital, at no charge to IOPO, for the purpose of facilitating the evaluation, maintenance, recovery, placement, and medical charting of Donors, in order for IOPO to provide Donor information to UNOS, and, if Hospital cannot provide a high speed Internet connection, Hospital agrees to work with IOPO to make the best alternative Internet connection available, which could include wireless Internet access cards or a dial-up connection;

i) provide an operating room with staff if needed (including surgical, anesthesia, and nursing) and materials deemed appropriate by IOPO for performing cadaveric Organ recovery, and assistance in performing all reasonably necessary tests and examinations, and if Hospital does not have appropriate operating room facilities, to follow procedures and protocols as specified by IOPO until such time as a potential Donor can be transported to another medical facility with appropriate facilities;

j) provide an itemized bill of all services for each Organ or Tissue Donor for which Hospital seeks reimbursement, and ensure that the family of an Organ or Tissue Donor, or person financially responsible for payment of the expenses for medical and surgical care for the Donor, is not charged or billed for expenses related to Organ or Tissue donation and to furnish to IOPO, upon request, an itemized statement of expenses billed to the Donor family or other responsible party, relating to the Donor's medical and surgical care and treatment to confirm that no such charges or bills were remitted, and to limit the total facilities or other charges for the procurement of Tissues to an amount not greater than $1,200;

k) work cooperatively with IOPO in the education of Hospital staff and the community regarding donation issues;

l) enter a notation in a patient's chart when Timely Referral is provided to IOPO;

m) cooperate with IOPO and provide the assistance of at least one qualified Hospital employee to assist in verifying that documentation, including Donor blood type and other vital data necessary to determine compatibility for purposes of transplantation,

specified in subsection 4. (u) of this Agreement that accompanies an Organ to a Transplant Center is correct;

n) cooperate with IOPO in performing death record reviews as specified in subsection 4. (v) of this Agreement; and, if required, to cooperate with IOPO in implementing actions deemed reasonably necessary to improve the opportunities for identifying Potential Donors; o) cooperate with IOPO in identifying, reporting, analyzing and preventing adverse events that may occur during Organ, Tissue or Eye donation at Hospital, as specified in subsection 4(u) of this Agreement, and cooperate with IOPO in taking all steps deemed reasonably necessary to prevent the repetition of adverse events during Organ or Tissue donation at Hospital; and

o) prepare and implement written policies supporting a program for monitoring the effectiveness of its Organ donation and procurement program by collecting and analyzing records regarding Potential Donors and referrals to IOPO, and Hospital's Conversion Rate data, and, where possible, taking steps to improve the Conversion Rate

6. Retention and Access to Records. In accordance with the Omnibus Reconciliation Act of 1980, 42 U.S.C. § 1395x(v)(I) and regulations thereunder, IOPO and Hospital agree that each shall retain and for four years after services are furnished by either hereunder, shall allow the Comptroller General of the United States and the United States Department of Health and Human Services, and their duly authorized representatives, access to this Agreement and to such of the books, documents and records of each as are necessary to verify the costs of services performed hereunder, provided that the said access is required by the cited law and regulations and further provided that the request for access complies with the procedural requirements of those regulations.

7. Independent Contractors. In the performance of all obligations hereunder, the relationship of Hospital and IOPO shall be that of independent contractors, and neither shall be deemed to be the partner or agent of the other, and no party shall withhold or in any way be responsible for the payment of any federal, state, or local income or occupational taxes, F.I.C.A. taxes, unemployment compensation or workers compensation contributions, or any other payments for or on behalf of any other party or any person on the payroll of any other party.

8. Professional Liability. IOPO and Hospital shall each, at all times, qualify and comply with the procedures to be and remain qualified health care providers pursuant to the Indiana Medical Malpractice Act, as amended, Indiana Code § 34-18-1-1 et seq. and shall maintain professional malpractice liability insurance coverage or other qualifying financial responsibility in accordance with the applicable liability limits or securities as specified therein, and pay the annual surcharges levied by the Indiana Department of Insurance.

9. Indemnification. Hospital and IOPO shall protect, defend, indemnify and hold harmless the other party from and against all claims, losses, demands, damages and causes of action, including reasonable attorney fees arising or in any way resulting from the indemnifying party's willful or negligent acts or omissions or the acts of the indemnifying party's agents or employees, in providing services pursuant to this Agreement. Said indemnification shall be limited to the maximum exposure permitted under Indiana Code § 34-18-1-1 et seq., unless insurance coverage in a greater amount is possessed by the indemnifying party.

10. Governing Law. This Agreement shall be controlled by and construed under, the laws and regulations of the State of Indiana and applicable federal laws and regulations.

11. Compliance with Social Security Act. The parties agree that all provisions of this Agreement shall be interpreted in such a manner as to comply with the requirements of Section 1138 of the Social Security Act, as added by Section 9318 of the Omnibus Budget Reconciliation Act of 1986 (42 U.S.C. § 1320b-8), and rules or regulations adopted pursuant to that law relating to Organ procurement.

12. Confidentiality of Patient Records. The parties agree to maintain the confidentiality of patient records pursuant to state and federal laws and regulations. However, to the extent permissible, the parties agree to cooperate in the exchange of information and records as may be necessary to carry out the terms of this Agreement, including obtaining information for inclusion in any IOPO originated donation chart as required by federal law. IOPO may disclose Donor medical and patient information to physicians providing treatment for Organ, Tissue or Eye recipients to entities that process or distribute Tissue or Eyes, to Transplant Centers receiving Organs, Tissue and Eyes, to the local coroner, and as may otherwise be required by applicable laws or regulations. IOPO may disclose medical and billing information to institutions providing reimbursement of expenses related to Organ donation and procurement.

13. Termination. This Agreement shall remain in effect until terminated by either party. Termination may be made by either party upon 90 days prior written notice to the other.

14. Waiver. The failure of any one party hereto to enforce any breach or to enforce any lack of performance of any covenants or obligations contained herein shall not constitute the waiver of that breach or of any similar subsequent breach of this Agreement.

15. Amendment. This Agreement represents the entire agreement between the parties hereto, and supersedes any prior stipulation,agreement, or understanding of the parties, whether oral or written. Any modification of this Agreement shall be invalid unless stated in writing and signed by both parties hereto.

16. Notice. All communications, notices and demands of any kind which either party may be required or desires to give or serve upon the other party shall be made in writing and sent by registered or certified mail, postage prepaid, return receipt requested, to the following addresses:

HOSPITAL

Community Hospitals of Indiana, Inc.
1500 North Ritter Avenue
Indianapolis, IN 46219
Attn: Contracts Management, Network Purchasing

IOPO:

Lynn Driver, President/CEO
Indiana Organ Procurement Organization, Inc.
3760 Guion Rd
Indianapolis, IN 46222

4606

Either party hereto may change its address specified for notices herein by designating a new address in accordance with this paragraph

17. Separable Provisions. If any provisions hereof shall be, or shall be adjudged to be, unlawful or contrary to public policy, then that provision shall be deemed to be null and separable from the remaining provisions hereof, and shall in no way affect the validity of this Agreement.

18. Discrimination. The parties hereby warrant that each party is and shall continue to be in compliance with the Civil Rights Act of 1964 and the Rehabilitation Act of 1973. No person shall, on account of race, color, religious creed, national origin, ancestry, sex, handicap or age be unlawfully excluded from participation in any program sponsored by either of the parties of this Agreement.

19. Debarment. IOPO and Hospital each represents and warrants to the other, that neither it nor any of its affiliates, officers, directors, subcontractors, or employees, is barred from participating in federal or state health care programs, or has been convicted of a criminal offense with respect to health care reimbursement. IOPO and Hospital shall notify the other immediately if the foregoing representation becomes untrue, or if it is notified by the Office of the Inspector General of the Department of Health and Human Services or other enforcement agencies that an investigation of IOPO or Hospital has begun which could lead to a sanction, debarment, or conviction.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized representatives as of the day and year first written above.

COMMUNITY HOSPITALS OF INDIANA, INC.

By: _____
Steve Bell, Vice President, Supply Chain

INDIANA ORGAN PROCUREMENT ORGANIZATION, INC.

By: _____
Lynn Driver, President and CEO

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TITLE: ORGAN AND TISSUE DONATION

Purpose:
1. To provide guidelines for health care providers for the process of organ/tissue donation and compliance with Indiana's Uniform Anatomical Gift Act IC 29-2-16-02

Policy Statements:
1. Community Hospitals are affiliated with Indiana Organ Procurement Organization (IOPO) for organ, eye and tissue donation. **All calls are to be made to the Indiana Donor Alliance (IDA), the telephone service for IOPO.** The toll free number is
2. No mechanical support should be withdrawn from the dying patient prior to the referral call to IDA and determination of medical suitability from IOPO.
3. The option of organ or tissue donation is to be offered to families by an IOPO representative to ensure the greatest sensitivity to matters such as timing, the circumstances of the patient's death and the beliefs and desires of those families.
4. Indiana's Uniform Anatomical Gift Act IC 29-2-16-02 provides means for a written, verifiable legal declaration of a patient's intent to donate anatomical gifts upon death. Any next of kin or guardian may not, under the law, supersede a patient's decision. Without a verifiable declaration, IOPO will follow the standard protocol of seeking family consent by offering the option of donation to the next of kin.
5. The monthly audit conducted by IOPO to identify areas of potential non-compliance will be forwarded to CHNw individuals and teams for review and action and made available to regulatory and accrediting bodies.

General Information:
Definitions:
1. Death: Individual who has sustained an irreversible cessation of all circulatory and respiratory function.
   All deaths include:
   - All cardiac deaths
   - All imminent deaths or patients who meet clinical triggers as measured by:
     - GCS of 5 or less
     - At first mention of withdraw of care
   - All still born births (where a death certificate is required)
   - DOA's (Dead on Arrival)
2. Brain Death: a sustained irreversible cessation of all functions of the entire brain, including the brain stem.
3. Imminent Death: Individual who has a condition from which a reasonable degree of medical certainty, there can be no recovery and that death will occur within a short period of time without instituting life-prolonging procedures. A patient who meets clinical triggers for organ donation.
4. Reportable Death: Deaths requiring a death certificate or fetal death certificate as required by Indiana State Department of Health. No reporting is required for abortions, miscarriages or fetal deaths less than 20 weeks gestation.
5. Organ Donation: Donation of solid organs which includes heart, lungs, liver, kidneys, pancreas and small intestines from an individual who is brain dead or meets criteria for donation after cardiac death.
6. Tissue Donation: donation of tissues, which includes heart valves, veins, arteries, tendons, ligaments, bone, fascia, skin corneas and whole eyes from an individual whose heart is no longer beating.

The hospital recognizes the importance of allowing those who wish to donate the opportunity, in the hope that solace may be provided to the grieving family by their decision to participate in improving the quality of life for others. CHNw wishes to facilitate the donation of organs, tissue and eyes in the board interest of society and those awaiting transplantation, without infringing upon a family's deeply held beliefs, values and rights.

IOPO provides information to the family of each potential organ or tissue donor regarding the desire of the patient for organ or tissue donation as designated on his/her Bureau of Motor Vehicles license or registration through www.donatelifeindiana.org. If the patient has not designated donation on his/her Bureau of Motor Vehicles license, the family has the option to donate or decline to donate organs or tissues. There will be no cost to the family of donors once the decision has been made to donate anatomical gifts.

To facilitate the opportunity for anatomical gift donation, the following processes involved with this procedure are identified:

1. CRITERIA for donation: See IOPO Manuals
2. CROSS REFERENCE:
   - Death — NPP: R-009 "Care of the Patient After Death"; See also attached Flow Chart
   - Autopsies: — CORP#: CLN-2054
   - Cardiac Death — CLN-3035, Donation organ – after cardiac death
   - Patient Rights Handbook

Procedure:

See attached flowchart

Owned by: Organ Donor Team

Approved by:

Organ Donor Team	12/2011
Risk Management	12/2011
Infection Prevention	12/2011
Chief Nursing Officer Designee	12/26/11

Approved: _____ Date:
Chief Executive Officer CHI/Chief Operations Officer CHNw

INTRODUCTION: ORGAN DONATION

Patients have the right to be organ or tissue donors upon their deaths, if they meet donor criteria. Indiana State Law and the Anatomical Gift Act require hospitals to offer the option of organ and tissue donation to all potential donors and/or families. In 1998 the Centers for Medicare and Medicaid, CMS required all health care organizations receiving Medicare reimbursement to call the local donor alliance organization for every anticipated and actual patient death. In Indiana, the donor alliance is the Indiana Donor Alliance, IDA confers with donor organizations to determine donor suitability and next steps.

Within the Community Health Network, staff members contact the IDA, who confers with out donor partners. For Community Hospital North, East, South and TIHH donor services are provided by the Indiana Organ Procurement Organization (IOPO). Community Anderson partners with Indiana Organ Procurement Organization (IOPO), Community Tissue Services (CTS) and Lions Eye Bank (LEB). The attached flowchart guides the caregiver through the process. Below are listed resources and experts.

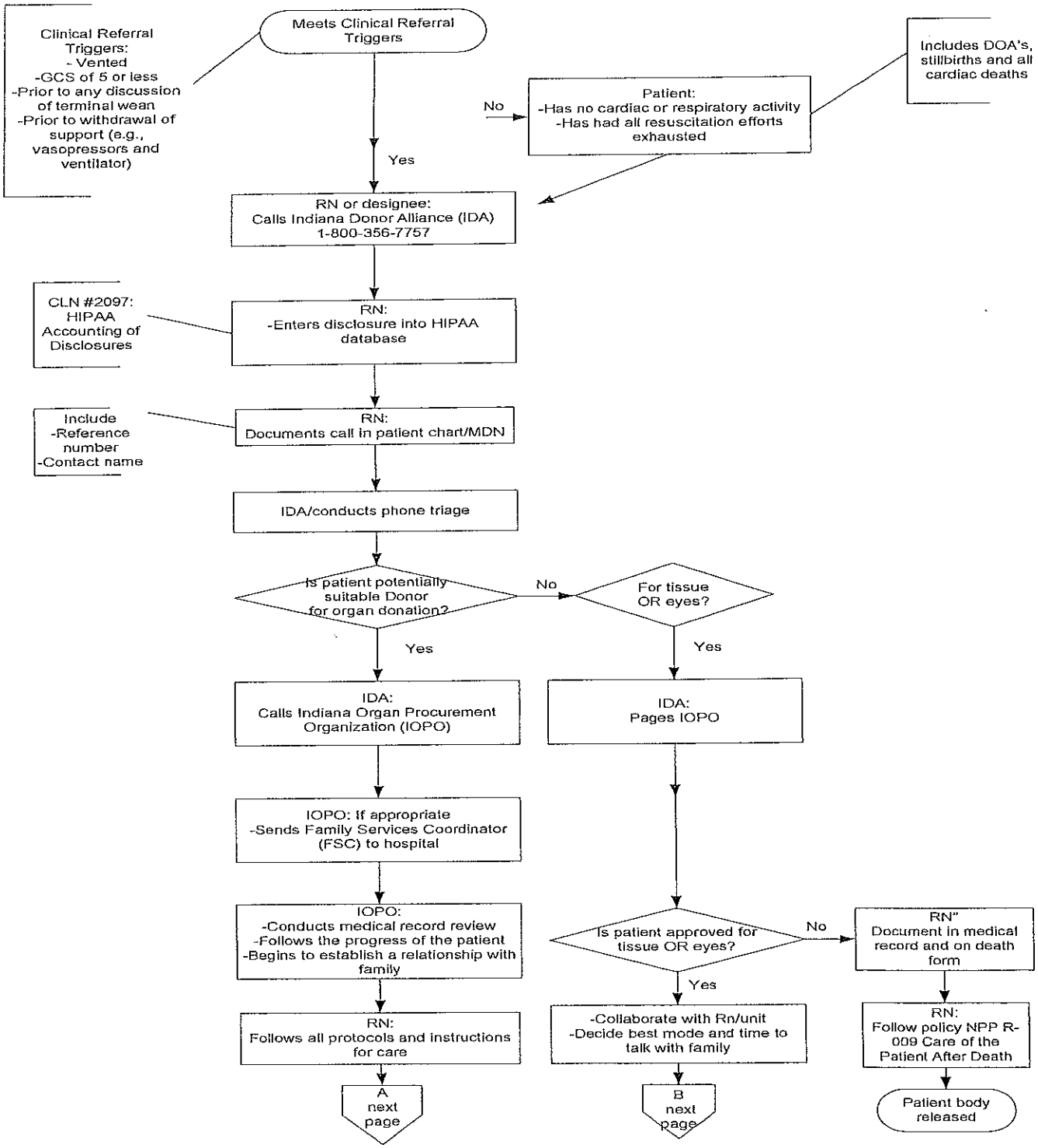
Indianapolis

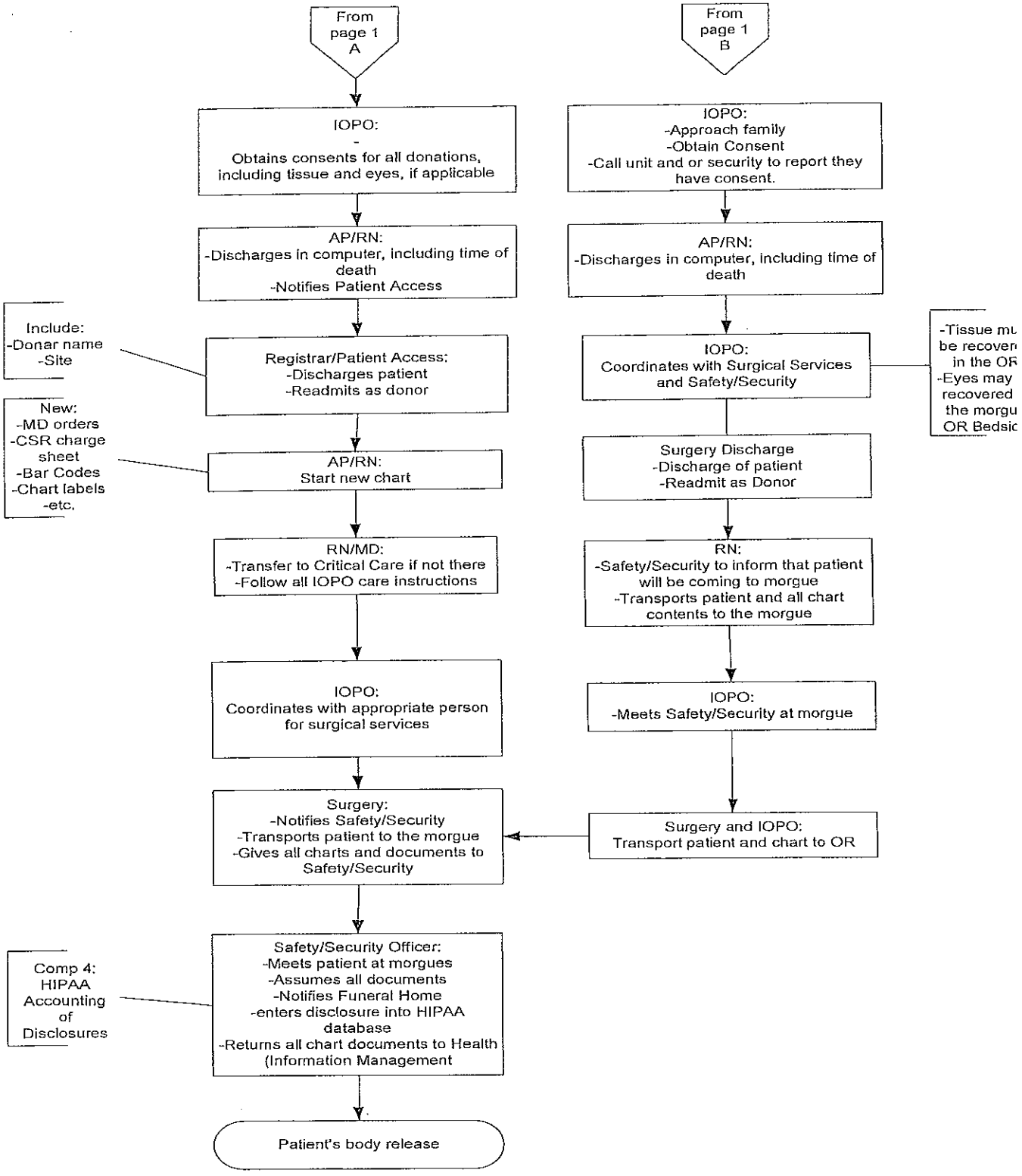
Experts/Resources
Network Donor Council Leader 1
Chaplains CHE CHN CHS
Ethics Committees (Call Medical Staff Office) CHE/N CHS
Indiana Donor Alliance (IDA)
Indiana Organ Procurement Organization (IOPO) iopo.org
Corporate Clinical Policy (CLN) 2055 "Organ & Tissue Donation"
Nursing Policy/Procedure (NPP) R-09 "Care of the Patient After Death"
Donation After Cardiac Death (Organ) CLN-3035

Anderson

Experts/Resources
Nursing Administration Pager
Indiana Donor Alliance (IDA)
Indiana Organ Procurement Organization (IOPO) iopo.org
Community Tisssue Services (CTS)
Lions Eye Bank (LEB) lionseyebank.org
Hospital Policy H8 "Anatomical Gift Donation"

Organ & Tissue Donation




From page 1 A
From page 1 B
IOPO:
-
Obtains consents for all donations, including tissue and eyes, if applicable
IOPO:
-Approach family
-Obtain Consent
-Call unit and or security to report they have consent.
AP/RN:
-Discharges in computer, including time of death
-Notifies Patient Access
AP/RN:
-Discharges in computer, including time of death
Include:
-Donar name
-Site
Registrar/Patient Access:
-Discharges patient
-Readmits as donor
IOPO:
Coordinates with Surgical Services and Safety/Security
-Tissue mu
be recover
in the OR
-Eyes may
recovered
the morgu
OR Bedsic
New:
-MD orders
-CSR charge sheet
-Bar Codes
-Chart labels
-etc.
AP/RN:
Start new chart
Surgery Discharge
-Discharge of patient
-Readmit as Donor
RN/MD:
-Transfer to Critical Care if not there
-Follow all IOPO care instructions
RN:
-Safety/Security to inform that patient will be coming to morgue
-Transports patient and all chart contents to the morgue
IOPO:
Coordinates with appropriate person for surgical services
IOPO:
-Meets Safety/Security at morgue
Surgery:
-Notifies Safety/Security
-Transports patient to the morgue
-Gives all charts and documents to Safety/Security
Surgery and IOPO:
Transport patient and chart to OR
Comp 4:
HIPAA Accounting of Disclosures
Safety/Security Officer:
-Meets patient at morgues
-Assumes all documents
-Notifies Funeral Home
-enters disclosure into HIPAA database
-Returns all chart documents to Health (Information Management
Patient's body release

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 19

Diversion Policy

19. "**Diversion Policy.** The hospital must provide a copy of its diversion policy and affirm that it will not be on diversion status more than 5% of the time. The hospital's documentation must include a record for the previous year showing dates and lengths of time for each time the hospital was on diversion."

Narrative Response and Discussion

The requirements of section 19 are met with a signed copy of Community Health Network's Diversion Policy. Included in this section is a signed letter from the director of the Emergency Department affirming that Community Hospital South will not be on diversion for than 5% of the time.

Community
Health Network

Community Hospital South
Emergency Department
1402 E. County Line Road
Indianapolis, Indiana 46227-0963
317-887-7200 (tel)
eCommunity.com

June 24, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital South's application for "in the ACS verification Process" for Level III Trauma Center designation.

The purpose of this correspondence is to inform the committee that I serve in the role of Director of Emergency Department at Community Hospital South. Enclosed you will find Community Health Network's Diversion Policy and the record of Community South's diversion time for the past year. I affirm that Community Hospital South will not be on diversion more than 5% of the time.

Respectfully,

Shawna A. Thomas RN, BSN
Director Emergency Department

Edward Diekhoff M.D., F.A.C.S
Trauma Medical Director

Community Health Network

CORPORATE CLINICAL POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 2/9/09; 5/23/12

CORP#: CLN-2087
Page 1 of 6
EFFECTIVE: 1-16-14

TITLE: READY TO SERVE/DIVERSION (AMBLUANCE DIVERSION)

Purpose:
To provide a plan for the orderly arrangement of staffing and patient placement during any situation that has the potential to cause a break in the provision of essential patient care and services. Examples include (but not limited to): a winter storm warning, internal or external disasters, Red Light Bed Alert and ambulance diversion.

Policy Statements:
1. The provision of high quality patient care is the primary focus of the Community Health Network (CHNw).
2. All departments that support patient care will maintain a roster which includes staff phone numbers, distance from the hospital and travel time to reach the hospital.
3. Staffing level that support patient care will be addressed if there is a Red Light Bed Alert, winter storm warning, code internal or external, or ambulance diversion.
4. In rare instances the need to consider diversion may be due to untoward patient volumes, high acuities, and compromised physical and/or available resources either in acute care or in the emergency department. In these situations, when there may not be sufficient patient beds and/or patient care staff to safely care for any additional patients, the delivery of ambulance patients to a facility may be temporarily diverted. The rationale of such a diversion is to allow optimal patient care, while causing the least amount of hardship to other hospitals, including other facilities in the CHNw, or to EMS providers.
5. When diversion is being considered:
   a. Only one (1) of the large metropolitan hospitals (excluding Eskenazi) will be on diversion at any one time; this includes Community Hospital East (CHE), St. Francis, St. Vincent, and Methodist.
   b. Only one (1) of the CHNw hospitals – East, North, and South –will be on diversion at any one time.
   c. In a rare instance when patient safety dictates more than one facility to divert at once negotiation and collaboration occurs between sites and leaders, eg ED Directors, Nurse Managers, and Facility President, frequently to remedy the situation. The CHE House Supervisor, after collaboration with DART is empowered to make whatever decisions are necessary to avoid diversion, this may include mandating certain patient placements or staffing patterns.
6. A recommendation for diversion is made by the Emergency Department (ED) Director after receiving data from the ED physician, the ED Patient Care Coordinator (PCC)/Charge Nurse, and the House Supervisor, The ED Director then communicates and collaborates with the Vice President (VP) of Patient Care Services or designee for that facility to finalize the decision and determine the official diversion status, ie total or critical. The Administrator on call will also be notified by the House Supervisor after hours. The cooperation of all site departments is necessary in order to implement this process. All patient care units, and all other applicable ancillary units, are expected to cooperate, negotiate in good faith, and work toward the common goal of managing patient flow and avoiding diversion.

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General Information:

1. **DIVERSION** (ambulance diversion): The process of requesting EMS units to temporarily refrain from transporting incoming ambulance patients to a particular facility. Most often, diversion is due to unmanageable patient volumes, acuities, compromised physical resources or environment, Per agreement with metropolitan Indianapolis hospitals and EMS providers, there are four (4) recognized categories of diversion:
   a. Critical Care Diversion – Diversion of patients likely to require the most intense level of care and services, and likely to be admitted to critical care beds and/or monitored beds.
   b. Total Diversion – Diversion of all incoming ambulance patients. (NOTE: In the case of the following patients, the situation may be evaluated on a case-by-case basis: laboring mothers, patients in cardiac or respiratory arrest, patients in extremis, or ambulances which are in very close proximity to the hospital.)
   c. Psych Diversion – At Community Hospital North (CHN), times exist when the Behavioral Health Pavilion must divert patients. In these instances, the Medical Director and/or Executive Director for Behavioral Health are in charge of making the decision and notifying the House Supervisor at CHE to initiate the diversion.
   d. Cath Lab Diversion – Due to equipment failure in this department, diversion of patients with complaints likely to require this department's services is called and EMS units are alerted to divert those patients in order that they receive optimum care.
   e. Specific Resource Diversion – This is not an officially recognized "diversion" status in the community at large. For example, CT scanner is non-functional or both CT scanners at CHE are not functioning. Diversion of patients with complaints likely to require that resource is called and EMS units are alerted to divert those patients in order that they receive optimum care. (in CT example, stroke, and head injury). This type of diversion lasts only until the resource/issue can be resolved.
2. **BEDS/PATIENT FLOW** - Bed Alerts are a declared situation and electronic communication is sent to alert the Network.
   a. YELLOW LIGHT - approximately 91% occupancy of core beds.
   b. BLUE LIGHT - indicates the number of ready/available beds exceeds the number of available staff.
   c. RED LIGHT - nearing 100% occupancy; indicates the number of inpatients or admissions has exceeded the number of beds available.
   d. Updated Bed Aggregation numbers for each facility are maintained at CHE in the House Supervisor's office.
   e. The CHE House Supervisor is responsible for initiating the Network Alert daily.
3. **DART (Diversion Avoidance Response Team)**
   a. The DART group convenes in person and/or via telephone when census/acuity is high, and diversion is a threat. The group's goal is avoiding diversion by whatever means possible, and they are empowered to do so by Senior Leadership. A meeting of this group is requested when it is felt that diversion issues may arise soon if plans are not implemented to alleviate patient overload. NOTE: If a diversion decision is needed emergently, the ED Director in consultation with the facility VP of Patient Care Services may make that decision emergently and DART can be convened forthwith to work on solutions to end the diversion status as quickly as possible.
   b. The DART is comprised of:
      - House Supervisor
      - Emergency Department Clinical Director or designee
      - Nursing Site Leaders
      - Ancillary Site Leaders, eg., Case Management, Environmental Services
      - Facility President

- Site-specific personnel as designated by Facility President

4. EMERGENCY STAFFING PLAN - consists of:
   a. Holding essential staff over for duty on subsequent shifts
   b. And/or recruiting staff from alternative sources within the hospital network
   c. And/or requesting transportation service through Security Dispatch for staff essential to patient care and who are unable to provide their own transportation
   d. And/or providing lodging quarters, supplies, food, and compensation for staff, volunteers, and contracted service employees
   e. The hospital may provide transportation for staff needed for essential patient care and services after all efforts for self-transportation have been exhausted. When making arrangements to pick up staff, the network commits to making arrangements to take staff back home via 4-wheel drive vehicles or prepaid taxi. However, the network cannot commit to the exact time staff will be taken home. The network cannot guarantee that there will be a sufficient number of 4-wheel drive vehicles (or taxi service) available to meet the demand for pick up and return.
5. CODE INTERNAL can include, but is not limited to loss of communications, utility failure (ie electric, water, medical gas, HVAC), bioterrorist threat, chemical spill or communicable disease outbreak. A Code Internal is a situation that has potential to disrupt the normal course of business, cause damage or create casualties.
6. CODE EXTERNAL can include but is not limited to bus/plane or multiple auto accident (resulting in patient influx), release of a toxic substance, bioterrorist attack terrorist attack or incident causing multiple injuries/casualties. A Code External at one site does not mean there needs to be a Code External initiated at all sites.
7. Electronic communication devices are used to notify the network of disasters, bed alerts, etc.
8. PAY PRACTICES: refer to Community Health Network Human Resource Policy and Procedure Manual.

Procedure:

DIVERSION

1. The ED identifies that it is unable to accommodate further patient influx.
2. The charge nurse in conjunction with the ED physician contacts the ED Director/designee, who will then coordinate efforts to alleviate the situation. The Director/designee will consult with the VP of Patient Care Services and the Administrator on call as needed to get the situation relieved. If the situation is not able to be relieved, the appropriate diversion may be called at this point.
3. The department notifies the CHE House Supervisor.
4. The CHE House Supervisor pages all CHNw leadership, utilizing the network emergency alpha pagers: "Dart Meeting" with time and meeting place.
5. The DART is immediately activated, as follows (unless previously activated):
   a. There is an immediate halt on all placements of admissions, while a rapid assessment of the situation is conducted; the halt applies to, but is not limited to the following areas/departments: ED, Operating Room (OR), Post Anesthesia Care Unit (PACU), Cardiac Cath Lab, and all inpatient and short stay/daybed units.
   b. Guidelines for this rapid but thorough assessment may include, but are not limited to:
      1.) Analysis of numbers of patients throughout the facility
         b.) in ED – total and those to be admitted
         c.) in the Cath Lab – currently and slated
         d.) the OR/PACU -- currently and slated
      2.) Assessment of number of available house beds, including pending discharges and transfers

3.) Assessment of bed utilization
   a.) Are all available beds being utilized?
   b.) Are there any beds on the Pediatric or Family Rooms units? (Note: Pediatrics can take patients up to age 25 without special permission; Family Rooms can take non-infectious female patients)
   c.) Does a unit (or units) need to "flex up"?
   d.) Can patients be held in closed areas, eg, Endoscopy or Ambulatory Care?
   e.) Can stable patients be temporarily placed in inpatient unit hallways?
   f.) What closed beds can be re-opened immediately? in one hour? in four hours?
   g.) Who else can be utilized to provide patient care - non-clinical and/or administrative nurses to provide direct patient care?

4.) Movement of patients
   a.) Has a particular patient's condition been upgraded, qualifying the patient for a lower level of care?
   b.) Can patients be transferred to another CHNw facility? (eg, cardiac patients going to CHVH the next morning for cardiac catheterization.)

6. If diversion is unavoidable, the CHE House Supervisor makes the following notifications, in this order, 24/7:
   a. Notify EMS:

CHE Hancock County – Buck and Sugar Creek	Mesh Indy TRAC System [redacted]
CHN/CHVH/Behavioral Care Hamilton County	Mesh Indy TRAC System [redacted]
CHS Brown Township	Mesh Indy TRAC System [redacted]

   b. Page all CHNw leadership, between 0600-2200, utilizing the network emergency alpha pagers: "Diversion" with what hospital and pertinent information related to the diversion.
7. CHE House Supervisor will log diversion information in the Network Diversion Log.
8. The entire situation will be re-evaluated, not less than every two (2) hours.
9. The diversion will be deactivated as soon as possible; the CHE House Supervisor will:
   a. Notify EMS, following the above steps, see 6.a.
   b. Page all CHNw leadership, between 0600-2200, utilizing the network emergency alpha pagers stating the diversion is over.
   c. The CHE House Supervisor will log the information in the Network Diversion Log.

DECLARING A YELLOW, BLUE OR RED LIGHT BED ALERT

1. Each unit/department assesses bed availability for potential problems. Notify the House Supervisor at CHE via alpha-numeric pager [redacted] potential problems.
2. The CHE House Supervisor assesses daily at 0500, 1300, 2000, and PRN the number of current inpatients at all 4 Indianapolis Community Health Network hospitals
3. The CHE House Supervisor evaluates the information from all sites to determine if a Bed Alert needs to be called. The CHE House Supervisor will assess which are the most appropriate units to place centralized staff when supply and demand do not match, eg skill mix, on-call procedures.
4. When a RED LIGHT is called, departments may be notified of the potential need to hold patients.

EMERGENCY STAFFING PLAN INITIATION:

1. Department Directors or designee determine staffing requirements for providing essential patient care and services (ie Nursing Service, Dietary, Laboratory, X-ray, and Maintenance) and initiate plans, which may include:
   a. Retain current staff.
   b. Recruit staff from alternative sources within the hospital network.
   c. Request transportation service
   d. For coordination, all nursing service units/departments communicate their individual nurse staffing status with Centralized Staffing ([redacted]

TRANSPORTATION SERVICES

1. Leadership arranges employee transportation with Security ([redacted] making the request as soon as possible but not more than three (3) hours prior to employee's scheduled start time.
2. Security determines transportation assignments, considering:
   a. Weather and road conditions.
   b. Employees located in close proximity to others may in some cases determine pick-up priorities.
3. Safety & Security coordinates requests for return transportation with pick up requests. Pick up requests have priority over return transportation. Return transportation is scheduled on a first come, first serve basis.
4. Transportation vehicle pool:
   a. All hospitals owned vehicles are available to the Transportation Pool
   b. Security Dispatch contacts the Director of Facilities Engineering or designee in regards to providing transportation assistance
   c. All drivers are issued a two – way radio or cellular phone.
   d. Security dispatch records driver mileage.
   e. Expenses (mileage) is recorded when non-hospital owned vehicles are used for the reimbursement of expenses under standard travel practices.
   f. Fuel reimbursement and hourly wages to hospital and non-hospital employees will be paid fuel reimbursement and hourly wages after receipts are turned into the Secretary of Safety and Security.

LODGING QUARTERS AND PROVISIONS:

1. If necessary, due to the projected length of severe, inclement weather or the projected length of the Internal Disaster, lodging quarters will be provided for employees who volunteer or are requested to stay in the hospital to staff projected vacancies.
2. Lodging will be coordinate by Environmental Services and House Supervisor.
3. Toiletries are coordinated through Materials Management.
4. Food services are coordinated by Nutrition and Food Services. The Cafeteria will be available during regularly scheduled meal periods.

Owned by: CHE House Supervisor

Approved by:		
	Infection Prevention	Date: 12/13
	Risk Management	Date: 12/13
	Safety and Security	Date: 12/13
	Emergency Department Directors	Date: 12/13
	Nutrition and Food Services	Date: 12/13
	Environmental Services	Date: 12/13

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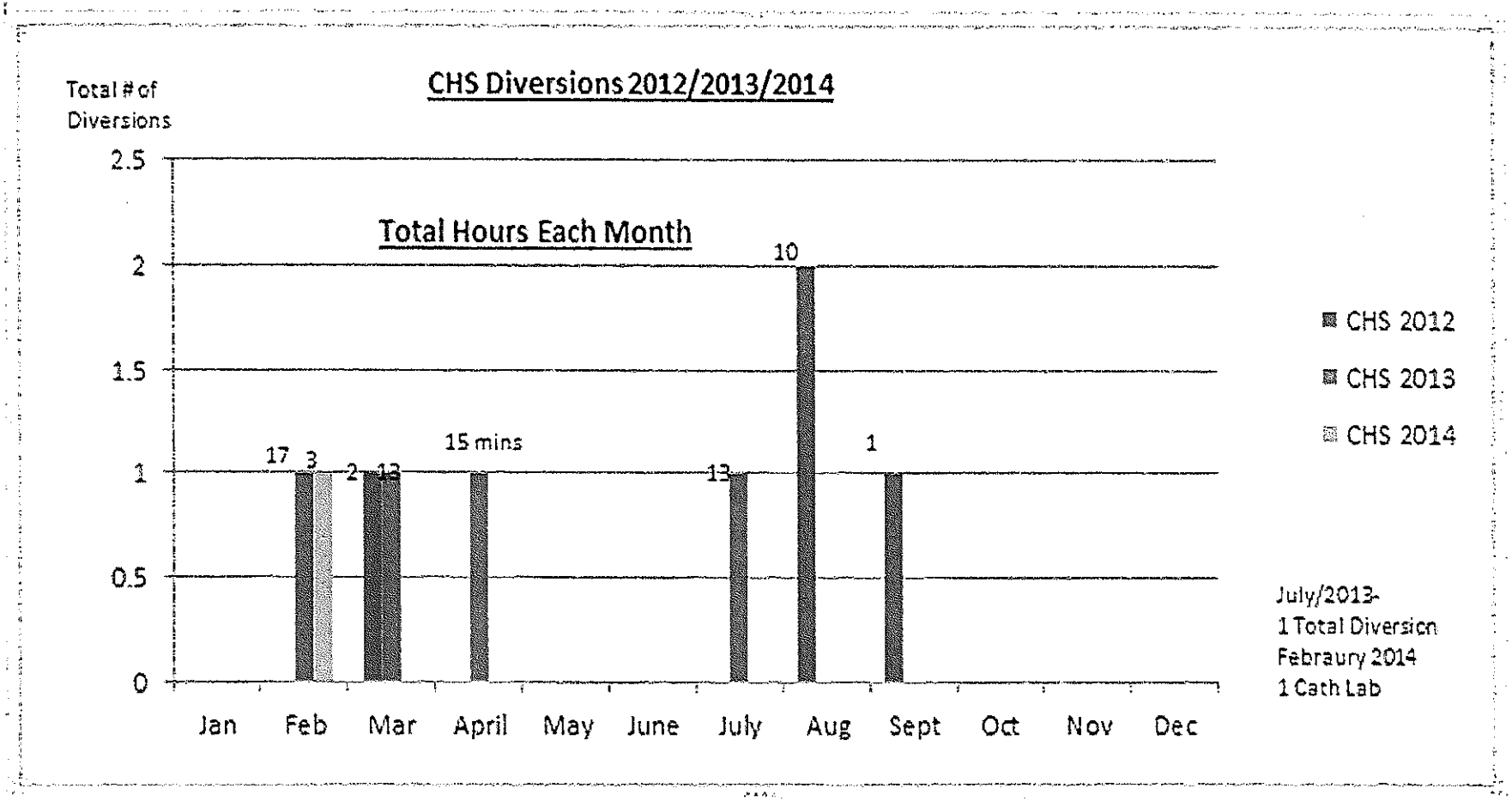
CNO Designee

Date: 12/13

Approved: _____

Network President/CEO

Date:


CHS Diversions 2012/2013/2014
Total # of Diversions
Total Hours Each Month
2.5
2
1.5
1
0.5
0
17
3
2
13
15 mins
13
10
1
Jan
Feb
Mar
April
May
June
July
Aug
Sept
Oct
Nov
Dec
CHS 2012
CHS 2013
CHS 2014
July/2013-
1 Total Diversion
Febraury 2014
1 Cath Lab

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Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 20

Operational Process Performance Improvement Committee

20. "**Operational Process Performance Improvement Committee.** There must be a trauma program operational process performance improvement committee and documentation must include a roster of the committee and meeting times for the previous year."

Narrative Response and Discussion

Performance Improvement and Patient Safety Committee has been formed and met prior to application. The agenda, power points, case reviews, and meeting minutes are included in this section. All committee members have been identified. The list of these of committee members is included in this application. As a group, we identified our quality indicators that we will use for performance Improvement for trauma at Community Hospital South.

Community
Health Network

Community Hospital South
Performance Improvement and Patient Safety Committee Members
June 2014

Trauma Medical Director- Dr. Edward Diekhoff M.D. F.A.C.S.

Trauma Program Manager- Roxann Kondrat BSN, RN

Emergency Department Director- Shawna Thomas BSN, RN

Trauma Registrar- Mary Schober

Emergency Physician – Dr. Parker/Dr. Bence

Operating Room/PACU – Patrick Beaupre

ICU – Jeannie Blizzard/Tony Reynolds

Orthopedic Surgeon- Dr. Julian

Neuro surgery- Dr. Rendell

VPCP – Dr. Lee

Radiology – Dr. Sheets

Respiratory – Ricki Shepherd

Lab/Blood Bank- Gabi Houston

EMS- Dr. Bence/John Zartman

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Community Health Network

Agenda
PIPS Meeting
June, 20, 2013

1. WELCOME /INTRODUCTIONS

2. LEVEL III TRAUMA APPLICATION PROCESS

3. WHAT IS PIPS?

4. WHO MAKES UP THE PIPS TEAM?

5. WHAT QUALITY INDICATOR MEASURES ARE WE USING FOR TRAUMA?

6. QUESTIONS?

7. NEXT MEETING FRIDAY JUNE 27, 2014 2PM-4PM IN CONFERENCE ROOM 5-6 AT CHS

4806

Community Health Network

Trauma Improvement Process Team CHS

June 20, 2014

Agenda

1. Welcome /Introductions

2. Level III Trauma Application Process

3. What is PIPS?

4. Who makes up the PIPS team?

5. What Quality Indicator measures are we using for Trauma?

6. Questions?

7. Next Meeting Friday June 27, 2014 2pm-4pm in conference room 5-6 at CHS

WELCOME/INTRODUCTIONS

- Trauma Medical Director- Dr. Edward Diekhoff M.D. F.A.C.S.
- Trauma Program Manager- Roxann Kondrat BSN, RN
- Emergency Department Director- Shawna Thomas BSN, RN

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Application Process for Level III Trauma Center

- Submission of application on or before July 7, 2014

- What Does this mean to us?

What is PIPS?
Performance Improvement and Patient Safety

Who? Everyone is responsible for PIPS. You must have a physician champion.

What? Not only improving the performance of the trauma team, but also evaluating potential areas for the need for improvement.

When? PIPS is done 24 hours a day, 7 days a week, 365 days per year!

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Who Makes up PIPS Committee?

- Trauma Medical Director- Dr. Edward Diekhoff M.D. F.A.C.S.
- Trauma Program Manager- Roxann Kondrat BSN, RN
- Emergency Department Director- Shawna Thomas BSN, RN
- Trauma Registrar- Mary Schober
- Emergency Physician – Dr. Parker/Dr. Bence
- Operating Room/PACU – Patrick Beaupre
- ICU – Jeannie Blizzard/Tony Reynolds
- Orthopedic Surgeon- Dr. Julian
- Neuro surgery- Dr. Rendell
- VPCP – Dr. Lee
- Radiology – Dr. Sheets
- Respiratory – Ricki Shepherd
- Lab/Blood Bank- Gabi Houston
- EMS- Dr. Bence/John Zartman

How Does the Process start?

- **What am I looking for?** Find patients through daily admission records, ED logs, designated reports.
- **Where do I look?** Look through ED admits, admits to specialties, and admits to the trauma surgeons. Other sources of information could be by personal communication (phone calls to your office, social worker, other staff).
- **Why am I looking for it?** This is what "drives" the PIPS process.

WHAT AM I LOOKING FOR?
QUALITY INDICATORS

- Time in ED
- Trauma Activation
- EMS Scene time
- EMS Issues
- Surgeon Response time for Code Traumas
- Surgeon on Call
- CT times
- Transferred/Where?
- Time decision was made to transfer?
- Pediatric Case
- Trauma Death
- Over/Under Triage
- Removal of Backboard
- Injury Severity Score
- Blood/Blood Products availability
- OR times

WHAT THINGS HAVE YOU FOUND THAT YOU FEEL NEED TO BE REVIEWED TO DETERMINE IF THE CONCERN IS A TREND, OR AN ISOLATED INCIDENT? WAS THE PATIENT CARE COMPROMISED? WAS THE OUTCOME LESS THAN OPTIMAL?

Levels Of Review

- **First level review**: Done primarily by the trauma coordinator who reviews the established filters and the overall case. Nursing issues are addressed by the trauma coordinator but must be communicated to the Trauma Medical Director.
- **Second level review:** Cases reviewed by the trauma coordinator needing physician review (physician champion). Keep in mind the physician cannot review their own cases so there may need to be a process for external review such as sending it to outside physician for review. The physician then decides if the case will go to PIPS for review.
- **Third level review:** Case has been reviewed by the trauma coordinator and trauma medical director and is now presented to the PIPS committee. PIPS committee will determine the final outcome of the case.

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PIPS Committee

- **What is it?** Monitoring, evaluating, and improving the performance of your trauma program.
- **Who attends?** The PIPS committee is comprised of physicians and allied health professionals who provide care to trauma patients. This provides the opportunity for discussion about patient care to occur with all disciplines able to participate in the review of the case.
- **Loop closure?** Loop closure describes what you did to resolve the problem, and how you educated all those involved in the problem!

Loop Closure

- How do I close the loop?
- Education
- Audits
- Accountability
- Re-evaluation

QUESTIONS?

Next PIPS Meeting

- Next Friday June 27, 2014 in CHS Conference Rooms 5-6

Community Health Network

PIPS Meeting CHS
June 20, 2014 1400

Minutes

Present:

Trauma Director - Dr. Diekhoff
ER-Dr. Parker
Radiology- Dr. Sheets
ICU-Tony Reynolds, RN
Trauma Registrar- Mary Schober
Lab/Blood Bank-Gabby Houston
VPCPER- Dr. Lee
Trauma Program Manager- Roxann Kondrat RN
EMS-Dr. Bence
Anesthesia- Dr. Corsaro
OR/PACU-Patrick Beaupre, RN
RT-Rickki Shepard
Neuro Surgery- Dr. Rendel
ED Director- Shawna Thomas, RN

Item #	Agenda Item	Purpose	Outcome/Next Step	Follow up Responsible Individual	Due Date/Timeline
1	Welcome/Introductions	Information	Roxann Kondrat BSN, RN –new Trauma Program Manager at Community South.		
2	Level III Trauma Applications Process	Information	Shawna Thomas RN- ED Director informed the committee that Community South Application for being a Trauma Center will be summited by July 7, 2014. We almost have our application complete.	Shawna and Roxann will finish and submit application to American College of Surgeons.	July, 7, 2014
3	What is PIPS?	Information	Roxann Kondrat- Presented a power	Power Point	

			point presentation on what it means to be on a performance Improvement and Safety committee.	Attached to minutes for review	
4	Who Makes up the PIPS Team?	Information	Trauma Medical Director- Dr. Edward Diekhoff M.D. F.A.C.S. Trauma Program Manager- Roxann Kondrat BSN, RN Emergency Department Director- Shawna Thomas BSN, RN Trauma Registrar- Mary Schober Emergency Physician – Dr. Parker/Dr. Bence Operating Room/PACU – Patrick Beaupre ICU – Jeannie Blizzard/Tony Reynolds Orthopedic Surgeon- Dr. Julian Neuro surgery- Dr. Rendell VPCP – Dr. Lee Radiology – Dr. Sheets Respiratory – Ricki Shepherd Lab/Blood Bank- Gabi Houston EMS- Dr. Bence/John Zartman Anesthesia- Dr. Corsaro		
5.	What Quality Indicator Measures are we using for Trauma?	Information	Time in ED Trauma Activation EMS Scene time EMS Issues Surgeon Response time for Code Traumas Surgeon on Call CT times Transferred/Where? Time decision was made to transfer?	Roxann/Dr. Diekhoff will review all trauma cases using these measures and bring trauma cases for review to the	

			Pediatric Case Trauma Death Over/Under Triage Removal of Backboard Injury Severity Score Blood/Blood Products availability OR times	committee.	
6	Questions?	Information	**LAB**-Gabby from lab informed us that we will have 1 Unit of Platelets in lab now. This brought up discussion about Massive Transfusion Policy. Shawna updated us, we are working on a corporate wide policy. **EMS-** Dr. Bence discussed the subject of what EMS will be bring to our ER once we become a Level III Trauma Center. Dr. Bence stated that he will be working with EMS to educate them on what patients are appropriate to come to Community South and which patients need to be transported to higher level of care facilities. The use of a "trauma phone" with EMS was brought up. This phone would be direct access to ER physician at Community South so that EMS could discuss a Trauma Case while they were on scene of the trauma. **Pediatric Patients:** we discussed who would admit these patients? Dr. Diekhoff stated that general surgery will be the admitting. We also discussed that ICU at		

			south does not admit patients less than 16 years of age. We discussed if pediatric trauma patients needed admission that they would be transferred to Higher Level of care. We will be reviewing all pediatric cases. **OR and Diversion-** Dr. Corsaro asked about increase in OR volume with Trauma Designation. Shawna informed him that since Community Anderson became "In Process" that they have not seen and influx of OR cases. Dr. Rendell asked about neuro -surgery cases and diversion related to neuro surgery in the OR. Shawna explained in those incidents we can go on neuro surgery diversion. Patrick informed us that he would help keeping the ER up to date if we would need to go on diversion related to a surgeon being in the OR. Shawna also explained sitting down with Neuro-Surgeons and discussing cases that they would want to keep at Community South and what cases transferred to higher level of care.		

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Agenda
PIPS Meeting
June, 27, 2013

1. Welcome
2. Update on Trauma Application
3. Review of cases
4. Trauma CME requirements for Physicians
5. Discussion of future meetings
6. Questions
7. Next Meeting Thursday July 3, 2014 will be cancelled.

Community Health Network

PIPS Meeting CHS
June 27, 2014 1400

Minutes

Present:

Trauma Director - Dr. Diekhoff
ER-Dr. Parker
Radiology- Dr. Sheets
ICU-Tony Reynolds, RN
Trauma Registrar- Mary Schober
Lab/Blood Bank-Gabby Houston
ED Director- Shawna Thomas, RN
Trauma Program Manager- Roxann Kondrat RN
EMS-John Zartman
Anesthesia/OR- Dr. Corsaro
RT-Ricki Shepard
Neuro Surgery- Dr. Rendel
VPCP- Dr. Lee
Orthopedic Surgeon: Dr. Julian

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Item #	Agenda Item	Purpose	Outcome/Next Step	Follow up Responsible Individual	Due Date/Timeline
1	Welcome	Information	Minutes were reviewed and past by motion by Dr. Corsaro and Dr. Sheets		
2	Level III Trauma Applications Process	Information	1. Shawna Thomas RN- ED Director informed the committee that Community South Application for being a Trauma Center will be summited by July 7, 2014. We almost have our application complete waiting on one signature. 2. John Zartman-explained the application process going through	Shawna and Roxann will finish and submit application to American College of Surgeons.	July, 7, 2014

			Homeland security and then to the EMS commission to inform ambulance services that they can bring trauma patients to community South- John Zartman also informed us the all ER lines are recorded for review later if needed	Roxann informed the group that Dr. Bence and she will work with EMS on providing education to what Trauma patients are appropriate to come to Community South.	
3	Review of Trauma Cases	Evaluation and Information		Trauma Case Reviews Attached to minutes.	
4	Trauma CME requirement for Physicians	Information	Roxann Discussed need for Trauma Surgeons, Orthopedic Surgeons, Neuro-Surgeons need 16 CME per year that will need to be tracked yearly for our Level III trauma designation. Dr. Julian discussed a network CME each year for all physicians to get 8hr of Trauma CME. Dr. Lee- asked what level CME is need Level one or two.	Roxann-will investigate CME requirements for Radiology and Anesthesia. She will also get CME requirements for all groups	Roxann will report back in next PIPS meeting.
5.	Discussion of future Meetings	Information	It was decided to have PIPS meetings every Fourth Thursday from 07am-08am		Roxann will send out a reminder

					of future dates
6	Questions?	Information	1. Dr. Julian – had some questions about Community South becoming a "dumping ground" from other hospitals now that we will have our Trauma III designation. He expressed concern that other hospitals do not have Orthopedic on-call daily their practice may become to dump patients at Community South. Dr. Parker explained if an outlying hospital does not have Orthopedic on per EMTALA we can no refuse transfer "because services are not available at other hospital" Dr. Parker stated he would work with the ER physicians to have these hospitals call Orthopedics and review case with them prior to transfer. Dr. Julian also stated that Dr. Macintosh will be taking call at Community South and needs to be added. 2. Dr. Sheets and Dr. Randel are concerned about "Code Trauma" Activations on pediatric patients. Roxann and Shawna explained that pediatric patient that need to be admitted will go to Riley's but we do see pediatric patients in our department and may get a	Shawna and Roxann will monitor transfer of Ortho cases to community South. Roxann will monitor activations for Pediatric and these cases will be reviewed.	

			Trauma that walks in our front doors and is not brought in by EMS. Trauma activation criteria will be made into Posters. There will be education coming out about calling Trauma's and posters will be made and placed all over ER and other area's to help with calling trauma's. Dr. Julian suggested the physician lounge; Roxann will have one placed there when they are made. 3. Dr. Diekhoff asked about FAST exam course.	Will work with Eskenazi on getting our physcians comfortable with this exam.	

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Case Reviews
06/27/2014
CHS PIPS Committee

2014	Code Trauma's	Trauma Eval's	Transfer	Discharge	Admit	Deaths	Surgeon Response
January							
February							
March							
April							
May							
June	0	0	7		9	0	0
Total	0	0	7		9	0	0

2014	Code Traumas < 30min response	Code Trauma No response	Total Cases	Response Total
Dr. Diekhoff				
Dr. Bowlds				
Dr. Clark				
Dr. O'Neil				
Over- Triaged		Goal < 30%	Defined as any called Trauma that was discharged from the ER	
Under-Triaged		Goal < 5%	Defined as any patient with an ISS ≥ 15 that is not called a Trauma	

Topic	Discussion	Follow Up
Follow up/Loop Closure:		

dlg

Community Health Network

Systems

Demographics	Case Studies/EMS Report/ Issues/ Concerns	Discussion	Follow-up
Name [redacted] Date of Service 05/10/2014 MR [redacted] Image Trend # Case #1 Time in ER: 2h56m Trauma Activation: N/A EMS Scene Time: No Report EMS Issues: No report Surgeon response time for T1: N/A Surgeon on Call: N/A CT time: 11m Transferred/Where?: admit Time Decision was made to Transfer: n/a Pediatric case: n/a Trauma Death: n/a Over/Under triaged: Under-triaged Removal of Backboard: n/a ISS: 29	**Case Summary:** 68 year old man presents to ER per EMS. Pt has had a few days of generalized weakness with multiple falls taking ASA, Plavix and Pradaxa daily. Pt states that 730am PTA he was driving having shortness of breath and abd/chest pain. Pt states took his b/p at home was low. Pt called EMS and EMS states enroute to ER patient went into cardiac arrest and CPR was performed with ROSC. Pt arrives to ER alert and states mild abd pain and shortness of breath. Pt seen by ER physician found on US to have free fluid in abdomen. Dr. Woodall consulted general surgery Dr. Bowlds who want a CT abd/pelvis done stat at 1219 Ct was done. Radiologist called Dr. Woodall in ER at 1231 to inform her patient has ruptured spleen. Blood ordered and hung. Pt to OR for splenectomy at 1338. Pt had 2 units of FFP, 2 units of Platelets, 8 units of RBC's in the OR. Pt admitted to ICU on levophed and intubated had prolonged recovery. **EMS Report:** Pt was transported by BLS **Issue/Concerns:** Questionable under triaged. Time in the ER. IIS >15, Pt developed pneumonia	We discussed as a group why this patient was not identified as a Trauma patient. The ER/EMS was unaware till later that patient had sustained a fall down a stair case two days prior. EMS responded to a patient not feeling well. There was a question why this patient with a blood pressure of 58/palp was transported by BLS crew? Pt prolonged time in ER was related to CT scan then the need for blood and platelets prior to going to the operating room. Pt has had prolonged recovery related to his multiple comorbidities.	Pt was discharged on post trauma day 26 to an acute rehab facility. Pt had peg tube placed before discharge unable to take PO. --- Vent days 10 ICU days 13
Demographics	**Case Studies/EMS Report/ Issues/ Concerns**	**Discussion**	**Follow-up**
Name [redacted] Date of Service 06/12/2014 MR [redacted]	**Case Summary:** This is a 2 year old female child that was running with BBQ skewer in her mouth and fell and it lodged into her mouth. Mother tried	This case the Radiologist Dr. Sheets states this child had a skewer externally through her	Pt was admitted overnight and went to surgery

Community Health Network

Image trend# Case #2 Time in ER: 1h35m Trauma Activation: no EMS Scene Time: unk EMS Issues: unk Surgeon response time for T1: n/a Surgeon on Call: n/a CT time: ? Transferred/Where?: Riley Time Decision was made to Transfer: 1846 Pediatric case: yes Trauma Death: no Over/Under triaged: under Removal of Backboard: n/a ISS: 1	to remove skewer and it meant resistance and called EMS. Pt arrived per EMS, child brought to ER IV, labs drawn CT scan ordered. Pt medicated for pain, Dr. Dwyer called Riley Children's hospital for Transfer 27mins into patient's arrival to the ER. Pt transferred to Riley's per EMS. **EMS Report:** Unable to obtain report **Issue/Concerns:** No activation of Trauma, CT ordered not done, No Temp documented, length of transfer	neck. Dr. Dwyer did get transfer going quickly to Rileys. Pt VSS entire ER visit. Multiple questions came up about activation "code trauma" on a stable pediatric patient. We discussed that if patient does not fit into tiered activation that it was up to the licensed medical professional to call it a Trauma or not. Also questions why this child was brought to Community South by EMS? Radiology states CT angio of neck was ordered on this child and this test would have needed the child be completely still and sedated with no movement to get proper test. Instead this child needs to get to Rileys for definitive care. Working with education for ER nurses and proper documentation.	to have skewer removed from her jaw. Discharge home post trauma day 1 doing well.

Demographics	Case Studies/EMS Report/ Issues/ Concerns	Discussion	Follow-up
Name [redacted] Date of Service 06/19/2014 MR [redacted] Image Trend#	**Case Summary:** 40 year old male, unrestrained driver with air bag deployed of an SUV that was travelling 60mph and he fell asleep at the wheel and rolled the SUV. Pt struck windshield with	The discussion on this patient was should this patient have come to us? Yes, patient was alert and oriented and was	Pt was discharged on Post Trauma day 2 stable. With dx

Case # 3				
<table><tr><td>Time in ER</td><td>4h2m</td></tr><tr><td>Trauma Activation</td><td>none</td></tr><tr><td>EMS Scene Time</td><td>unk</td></tr><tr><td>EMS Issues</td><td>unk</td></tr><tr><td>Surgeon response time for T1</td><td>N/A</td></tr><tr><td>Surgeon on Call</td><td>Diekhoff</td></tr><tr><td>CT time</td><td>16m</td></tr><tr><td>Transferred/Where?</td><td>admit</td></tr><tr><td>Time Decision was made to Transfer</td><td>n/a</td></tr><tr><td>Pediatric case</td><td>n</td></tr><tr><td>Trauma Death</td><td>n</td></tr><tr><td>Over/Under triaged</td><td>under</td></tr><tr><td>Removal of Backboard</td><td>Not documented</td></tr><tr><td>ISS</td><td>1</td></tr></table>	head. EMS had to extricate him with jaws of life from car. Pt was brought to the ER with mild RLQ pain. A&Ox4 during extrication and upon arrival. Pt had multiple CT scan and x-rays done. Dr. Sanders spoke with Eskenazi Trauma team at (2009) they felt CHS could handle this Trauma patient for OBS overnight and but, the Trauma MD from Eskenazi informed Dr. Sanders if she didn't feel CHS could handle this patient they would be happy to take them.(2021) Dr. Diekhoff called and accepted patient for admission overnight. **EMS Report:** Unable to obtain report **Issue/Concerns:** no trauma activation called, no documentation of full set of vitals, or backboard removed	walking at scene per EMS. Pt was trying to refuse transport but EMS informed him he should go to the ER for evaluation. Pt was stable in ER his entire stay. Pt admitted overnight for observation after significant MVC. Pt was found to have severe sleep apnea and was worked up in the hospital for that while he was here. It was also discussed on getting Alcohol and Drug screens on all Trauma patients it wasn't till two days later that patient admitted to cocaine use the AM of his accident. This information would provide the physician additional information on patients need for telemetry and make them aware to monitor them for withdrawal symptoms. It was also identified need for complete charting by nursing staff. Education will be provided	of obstructive sleep apnea and having some abrasion from MVC.

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Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 21

RN Credentialing

21. "**Nurse Credentialing requirements.** Briefly describe credentialing requirements for nurses who care for trauma patients in your Emergency Department and ICU."

Narrative Response and Discussion

The requirements of section 21 are met with a copy of the Operational Guideline: Education Requirements for the Care of Trauma Patients. This covers the credentialing requirements for ED and ICU nurses. Also enclosed is a spreadsheet showing which level of additional training each RN and Paramedic have received.

OPERATIONAL GUIDELINE: EDUCATION REQUIREMENTS FOR THE CARE OF TRAUMA PATIENTS

OBJECTIVE:
To define continuing education requirements and expectations of nursing staff who care for the acute trauma patient.

PROCEDURE:

A. Each associate will be responsible for maintaining their continuing education requirements. Adherence to this guideline is strongly encouraged for CHNw nursing team member that cares for patients on the Trauma Service including supplemental associates (PRN).

   It is the responsibility of each nursing team member to participate in and maintain accurate documentation of their continuing education credits/units. Copies of continuing education credits/units should be given to department leadership and submitted to the appropriate credentialing organization in a timely manner.

B. Indicated verifications are recommended within 18 months from date of hire for new nursing team member or 18 months from the effective date of this guideline, unless otherwise specified. Priority will go to new nursing team members, followed by currently employed nursing team members without trauma experience, and finally, currently employed nurses with trauma experience.

C. See attached table for a complete list of education requirements by individual unit.

Staff	Requirement
Emergency Department ***Nursing staff caring for patients on the trauma service.**	o Completion of organizational, departmental and job-specific orientation. o Four contact hours trauma-related education annually. o Advanced Cardiac Life Support (ACLS) o Trauma Nurse Core Course (TNCC) or Advanced Trauma Care Nursing (ATCN) o Encourage certification in the practitioner's area of specialty (i.e.- CEN, CCRN, etc.)
Operating Room	o Completion of organizational, departmental and job-specific orientation. o Four contact hours trauma-related education annually. o Advanced Cardiac Life Support (ACLS) o Encourage certification in the practitioner's area of specialty.
ICU/PACU/PCU	o Completion of organizational, departmental and

	job-specific orientation. o Four contact hours trauma-related education annually. o Advanced Cardiac Life Support (ACLS) o Trauma Nurse Core Course (TNCC), Advanced Trauma Care Nursing (ATCN), or Essentials of Critical Care Orientation (ECCO) o Encourage certification in the practitioner's area of specialty.
Medical-Surgical Units	o Completion of organizational, departmental and job-specific orientation. o Four contact hours trauma-related education annually. o Encourage certification in the practitioner's area of specialty.

Name	Role	ACLS	PALS	TNCC	ENPC	PHTLS
lexander, Billie J	RN	X				
Ames, Dana N	RN	X	X	X	X	
Applegate, Megan M	RN	X	X	X	X	
Brown-Fortner, Nikole M	RN	X	X	X		
Bullard, Brittany M	RN	X	X	X		
Cain, Stephanie A	RN	X	X	X		
Campbell, Kati M	RN	X	X	X		
Carlson, David W	Medic	X	X			
Davis, Angela D	RN	X	X	X		
Deckard, Robert R	Medic	X				
Dennison, Michael A	Medic	X	X			
Fields, Emily D	RN	X	X			
Findley, Kari E	RN	X	X			
Fleck, Bryan S	Medic	X	X			
Frey, Megan M	RN	X	X			
Furby, Krista R	RN	X	X			
Gill, Lori R	RN	X	X	X	X	
Goins, Betty L	RN	X	X			
Gonzalez, Amanda D	RN	X	X			
Hagerty, Valerie L	RN	X	X			
Harmon, Joshua L	RN					
Haston, Gary L	RN	X	X	X	X	
ayes, Brittney C	RN	X	X		X	
Hendricks, Martin N	Medic	X	X			
House, Angela J	RN	X	X		X	
Huffman, Sarah G	RN	X	X			
Jarrett, Chastity J	RN	X	X	X		
Johnson, Rebecca R	RN	X	X	X		
Johnson, Sharon K	RN	X		X		
Johnson, Tiffany L	RN	X	X	X	X	
Kappes, Dawn M	RN	X	X	X		
Klingler, Christina R	RN	X	X	X		
Lavin, Jennifer L	RN	X	X	X		
Leach, Brittany E	RN					
Markov, Alex J	RN	X	X			
McCreery, Alice F	RN	X	X			
Meadors, Courtney L	RN	X	X			
Medanic, Laura M	RN	X	X	X		
Meier, Jennifer A	RN	X	X			
Olmstead, Tiffany S	RN	X	X			
Penn, Melissa A	Medic	X	X			
Petty, Julia B	RN	X	X	X		
Phillips, Christopher D	Medic	X	X			
Preston, Steven K	Medic	X	X			
ice, Pamela S	RN	X	X	X	X	

Name	Role	ACLS	PALS	TNCC	ENPC	PHTLS
Pursell, Robert G	RN	X	X	X	X	
Ramsey, Myla A	RN	X	X	X	X	
Remillard, Amy D	RN	X	X			
Reynolds, Jessica S	RN	X	X	X		
Rooksberry, Hannah S	RN	X	X	X	X	
Rushton, Tiffany M	RN	X	X	X	X	
Sanford, Timothy P	RN	X		X		
Shaffer, Jessica L	RN	X	X			
Sheffler, Jennifer D	RN	X	X	X		
Smith, Paul M	RN	X	X	X	X	
Smock, Cheryl	RN	X	X	X	X	
Soots, Diana D	Medic	X				
Swain, Mary	LPN	X				
Swann, Jolanda L	RN	X	X	X	X	
Thomas, Shawna A	RN	X		X	X	
Trusty, Marcia E	RN	X	X	X	X	
Wilson, Daneen L	Medic	X	X			
Wolf, Jessie L	RN	X	X	X		
Wood, Amanda L	Medic		X			
Zawada, Melissa R	RN	X		X		

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 22

Governing Body and Medical Staff Commitment

22. "**Commitment by the governing body and medical staff.** There must be separate written commitments by the hospital's governing body and medical staff to establish a Level III Trauma Center and to pursue verification by the American College of Surgeons within one year of this application and the achieve ACS Verification within two years of the granting of "in the process" status. Further, the documentation provided must include recognition by the hospital that if it does not pursue verification within one year of this application and/or does not achieve ACS verification within two years of granting "in the process" status that the hospital's "in the process" status will immediately be revoked, become null and void and have no effect whatsoever."

Narrative Response and Discussion

The requirements of section 21 are met with a signed letter from the Chairman of the Board of Directors affirming understanding of "in the process" for Level III Trauma designation as well as the requirements for obtaining ACS verification.

Community
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June 9, 2014

William C. VanNess II, M.D., Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Application for hospital to be designated "In the ACS Verification Process"

Indiana State Trauma Care Committee:

The Community Health Network Board of Directors endorses the establishment of a Level III trauma center at Community Hospital South. It is our understanding that a favorable approval recommendation from the EMS Commission will allow any EMS Provider to take trauma patients to this facility, thus, providing Community Hospital South the opportunity to receive the patients necessary to demonstrate a track record of excellent trauma care.

Furthermore, the Board of Directors understands that if the hospital does not pursue verification within one (1) year of the application and/or does not achieve ACS verification within two (2) years of the granting of "In the ACS Verification Process" status that the hospital's "In the ACS Verification Process" status will immediately be revoked, become null and void and have no effect whatsoever.

We will provide the leadership and corporate culture to continue to deliver excellent patient care and more specifically demonstrate an exemplary trauma care system to achieve and maintain American College of Surgeons verification as a Level III Trauma Center. Thank you for the consideration of this application.

Respectfully,

Mike Peterson
Chairman, Board of Directors
Community Health Network

MP/jch

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Community
Health Network

Community Hospital South
Emergency Department
1402 E. County Line Road
Indianapolis, Indiana 46227-0963
317-887-7200 (tel)
eCommunity.com

June 23, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital South's application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The Medical Executive Committee of Community Hospital South supports the establishment of a Level III trauma center. It is our understanding that a favorable approval for recommendation from the EMS Commission will allow any EMS provider to take trauma patients to the facility, thus providing Community Hospital South the opportunity to receive the patients necessary to demonstrate a track record of excellent trauma care.

Furthermore, the Medical Executive Committee understands that if the hospital does not pursue verification within one year of application and/or does not achieve ACS verification within two years of the granting of "in the ACS verification process" status, that the hospital's "in the ACS verification process" status will immediately be revoked, become null and void and have no effect whatsoever.

Respectfully,

Kevin Julian M.D.
Chief of Staff

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